DOCUMENT RESUME

ED 047 992 SE 010 871

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TITLE School Health Services Guidelines, Revised.
INSTITUTION New Jersey State Dept. of Education, Trenton. Div. of Curriculum and Instruction.
PUB DATE 70
NOTE 150p.

EDRS PRICE EDRS Price MF-$0.65 HC-$6.58
DESCRIPTORS Curriculum Development, *Educational Administration, Educational Programs, *Guidelines, *Health Education, Health Guides, Health Services, *School Health Services

ABSTRACT

This manual is intended to serve as a guideline for school administrators and personnel who are concerned with the health education of school age children. Because of the different and complicated health problems now facing children and youth, it is deemed imperative that new priorities be established. Thus, policies and methods of school health programs and services outlined here are designed to help local school districts in the assessment of existing programs and in the development of new policies and procedures. Topics covered include: responsibilities of school personnel, health appraisal and medical examinations, supportive and special health programs, first aid and emergency care, school laws, and State Board of Education rules and regulations for health. Quick reference to some of the information is provided through occasional use of charts and lists. (BI)

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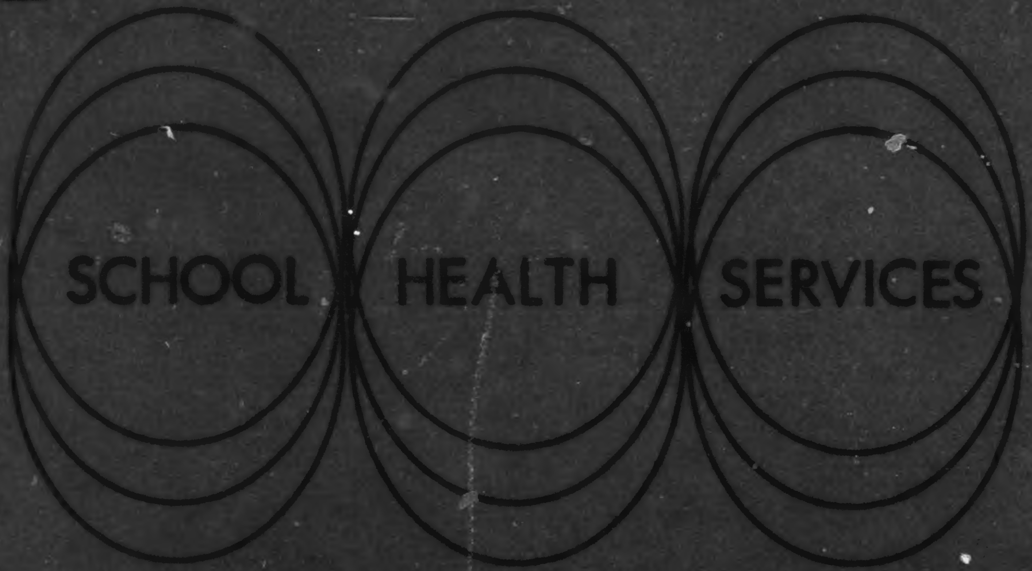

SCHOOL HEALTH SERVICES

guidelines

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STATE OF NEW JERSEY
DEPARTMENT OF EDUCATION
225 WEST STATE STREET
TRENTON 08625

DIVISION OF CURRICULUM AND INSTRUCTION
Office of Health, Safety and Physical Education

1970
Revised

Published by the New Jersey Department of Education, Division of Curriculum and Instruction.

State Board of Education: George F. Smith, President; Mrs. Hugh Auchincloss, Vice President; Harvey Dembe; Mrs. Marion G. Epstein; Martin S. Fox; Calvin J. Hurd; Mrs. Leonard L. Mancuso; Joseph L. Richmond; Harry Seals; Jack Slater; William A. Sutherland.

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"The child under whose searching hands the lump of wet clay takes form is making his own creation. The child who discovers books is finding new understanding. The child who is able to explore freely the universe of sound, movement, color, words, relationships is finding his own place in the world from which he can surely receive much richness and from which he may uniquely give richness in return."

Katherine B. Oettinger
Chief, Children's Bureau (1957-1969)
U.S. Department of Health,
Education and Welfare

FOREWORD

This manual is intended to serve as a guideline to school administrators and personnel who are concerned with the health of school age children.

No school can avoid having a health program. It may be haphazard or purposeful but every school has one.

The reasons for this are obvious:

1) The basic philosophy of each school includes a primary concern for the health of young people and is dedicated to helping each pupil achieve his optimal development mentally, physically, socially and emotionally.

2) Children bring to school with them a myriad of health needs and problems. Parents have the basic responsibility for the health of their children; the school's concomitant role is to help parents recognize and carry out their responsibility.

The policies and methods outlined here are designed to help local school districts in the assessment of existing programs and in the development of new policies and procedures. The different and complicated health problems now facing our children and youth make it imperative that new priorities be established. Many activities which have long been a repetitive procedure with little value must be abandoned or given a position of lesser importance.

We can no longer afford to be complacent and to resist change where change is needed. At present, educational programs are making an earnest endeavor to focus on the needs of the individual child. The basic objective is to assure that each child functions at his optimal level. The primary responsibility of the school health program should be to facilitate the accomplishment of this educational goal.

When we come to evaluate our programs, some of the questions we should ask are:

What is the structure of the school health program now? Has it become crystallized into fixed and inflexible patterns reflecting the needs of an earlier era?

Are the evolving trends in education having a direct impact on the kinds of health services provided?

What are we doing to meet the special needs of the gifted, the handicapped, the adolescent, the emotionally disturbed, the potential drop-out, etc.?

What is needed? Personnel? Facilities?

What will it cost?

How do we go about making change?

These and many other pertinent questions must be answered in a sufficiently comprehensive way to give us guidelines for evaluation and improvement.

In the past three decades, school health services has evolved from an emphasis on control of communicable disease to the present wide range of activities designed to meet the needs of each individual child. This process, if developed properly, can become a gold mine for the health of people. If school and community will combine their efforts in mining the gold with imaginative new methods of evaluation and research, they will make an invaluable contribution to a richer culture of health for the people of the world.

Carl L. Marburger
Commissioner of Education

ACKNOWLEDGEMENTS

This revision of School Health Services Guidelines is based on the original materials prepared as a cooperative effort by the advisory committee of the New Jersey State Department of Education, Division of Curriculum and Instruction and special committee from the New Jersey State School Nurses' Association and the New Jersey State School Nurse Supervisors' Association.

Grateful acknowledgement is made to all who contributed to the original bulletin.

The present materials were prepared through generous contribution of time and material from many professionals who are concerned with the development of each child's well being.

Appreciation is expressed to William A. Kemick, M.D., Special Consultant in School Health Services; William J. Farley, M.D. Past President, New Jersey School Physicians Association, Nutley; Avrum Labe Katcher, M.D., Director of Pediatric Services, Hunterdon Medical Center, Flemington. The materials on Responsibilities of the School Physician and Pupil Health Appraisal – Medical Examination were developed through the efforts of these pediatricians and their committees.

The Guidelines for hearing conservation were prepared through the efforts of Aris M. Sophocles, M.D., Trenton; Joseph R. Burns, M.D., Trenton; Annette Zaner, Audiologist, Mount Carmel Guild, Speech and Hearing Diagnostic Center, Newark; Robert A. Muzzarelli, Audiologist, Coordinator Speech and Hearing Center, Mercer Hospital, Trenton; Walter A. Petryshyn, M.D., Upper Montclair.

Special gratitude is due the following school nurses from Burlington County School Nurses' Association who made a careful study of the original guide and suggested changes for the revision: Bertha Dorman, Burlington County Child Study Team; Carmella F. Hughel, Chairman; Katherine Jefferson, President of the Association; Lillian Smith, Selma Walker, Virginia Austermuhl, Agnes McLarney, Ruth Ditmars, Orva Wilkinson, Rosalind Urian, Anne Bisignano, Harriet Bender, Ruth Pinkerton, Barbara Sharp, Carol Chabrol, Viola Gale, Aletta Prichton, Clare Regn and Elizabeth Pillsbury.

Appreciation is also expressed to Arlene Black, Supervisor, Cherry Hill, Evelyn Lawson, North Hunterdon Regional High School and Catherine J. Moore, Blackwood.

Dr. Everett L. Hebel, Director, Office of Health, Safety and Physical Education and his staff cooperated in the preparation of this revised guide.

It is hoped that the contributions made by these skilled professionals in child health will serve to facilitate and improve school health programs throughout the state.

Lillian H. Haufler, Editor
Assistant in Health Education

PART I

THE RESPONSIBILITY OF THE SCHOOL IN PROVIDING A HEALTH PROGRAM

The school has a grave responsibility and an exceptional opportunity to influence the health of the school children and, consequently, succeeding generations. The facilities of the school place it in a strategic position to further the health of the nation through preventive measures, positive instruction in personal and community health, supervised and graded physical education and the establishment of a mental and physical environment conducive to good growth and development. With a planned program of instruction K-12 the school is able to provide learning experiences which will influence the knowledge, attitudes and practices relating to group and individual health.

The primary purpose of health education is to change the health behavior and attitudes of the student so that he will take more and more responsibility for his own health and his family's and have an interest in the health status of the community.

The students who are attending our schools are going to have to face problems which will require the students to have accurate information and take intelligent action. The non-communicable chronic and degenerative diseases such as cardio-vascular conditions, cancer, diabetes and many others cannot be dealth with adequartely by a misinformed and uneducated person. Fluoridation, radiation, services for the mentally and physically handicapped present problems which require scientific health knowledge so that individuals may have a factual basis for their health attitudes and behavior.

Good health and freedom from illness cannot be attained through the efforts of medicine and public health alone, for where medicine and public health *do things for* people, the great need is to inform and to motivate the young and the old to *do for themselves* that which is good for their own health and that of others.

To learn effectively a child needs good health. Health is essential to achieve any goal. Children and youth respond more readily in the development of desirable health attitudes and practices than do adults.

Therefore, the earlier an individual learns the elements of healthful living the more likely it is that those elements will be applied.

The practice of healthful living is becoming increasingly complicated in this complex age. School administrators should assume leadership in providing the youth of our nation with basic health knowledge and promote the development of favorable attitudes which will result in desirable habits and behavior.

Our school health program, then, has three basic purposes:

1. Acquisition of knowledge.

2. Development of attitudes and ideals which will motivate each individual to attain the highest possible level of well-being.

3. Establishment of practice essential to health.

The job is not only to give knowledge, but also to help children acquire attitudes which will in turn motivate their behavior, which will result in better health, not only for themselves but for others.

Health is a comprehensive term, encompassing the physical, mental and emotional well-being of the individual.

The school health program encompasses the following three areas:

A. *School Health Services* — the procedures used by physician, nurses, teachers, and others designed to appraise, protect, and promote optimum health of students and school personnel.

1. Appraisal of health status of pupils, health histories, physical exams, screening tests, teacher observation.
2. Counseling school personnel; interpreting to pupils and parents the nature and significance of health problems; encouraging correction of remediable defects; formulating plan of action.
3. Emergency care for those injured or suddenly ill — policies and procedures.
4. Helping to prevent and control communicable disease.
5. Identification and education of exceptional children.
6. Correction of defects — those within the ability of the school.
7. Maintaining health of school personnel.

B. *Healthful School Environment* — the physical, social, and emotional factors of the school setting which affect the health, comfort, and performance of an individual or group.

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1. Physical environment
    - Safe school facilities, school sanitation, adequate housekeeping
    - Lighting and acoustics; heating and ventilation
    - Water supply and waste disposal
    - School construction, grounds, and equipment
    - School lunch program; school bus program
2. Mental, emotional, and social environment
    - Healthful arrangement of the school day
    - Friendly teacher-pupil and pupil-pupil relationships
    - Recognition of individual differences
    - Sound administrative policies
    - Ample time for play and recreation

C. *Health Science Instruction* – organized health teaching procedures directed toward developing attitudes, understandings, conduct relating to individual and group health.

1. Separate health instruction classes – concentrated direct teaching.
2. Integrated and correlated health education with other subjects and services.
3. Incidental teaching.
4. Health education of parents and other adults.

RESPONSIBILITIES OF SCHOOL PERSONNEL FOR SCHOOL HEALTH PROGRAMS

School systems in New Jersey differ in their facilities for carrying on a school health program. Every type of school is represented, from the large system with the services of many specialized personnel to the small elementary school where one or two teachers bear the responsibility for the health program.

The responsibilities of various personnel that are outlined in the following pages have been stated to indicate some of the elements which should be included in an ideal school health program.

The School Board

Ultimate responsibility for the school health program is that of the board of education, the elected representatives of the people of the school district. In practice the school board usually delegates this responsibility to its superintendent or chief school administrator. It is the superintendent or principal who organizes and directs the school health program, and who arranges the necessary working relationships between the school and other agencies or health authorities. However, these responsibilities may be delegated to the school health coordinator by the superintendent.

The board of education must provide the funds for the maintenance of the school health program. It is the school board which authorizes the employment of necessary school health personnel, which include a school nurse and other professional persons such as a school physician and a school dentist. The board also authorizes or adopts the policies under which the school health program operates.

The board of education has major responsibility for the provision and maintenance of school building facilities that are conducive to safe and sanitary housing of both students and instructors.

The board is responsible for the provision of an adequate water supply and a proper sewage disposal system for the school. It authorizes the erection of new school buildings and the making of additions and alterations to existing buildings. Space and equipment necessary for the operation of a sound health program should be provided for the personnel employed to administer this program.

As established by statute, plans covering new construction and alternations shall be submitted to the state departments of education and health and approval of such plans must be secured from these departments before construction can proceed.

Responsibilities of the School Administrator

The primary responsibility for successful functioning of the school health program rests with the school administrator. Less than satisfactory results will be attained unless he accepts this responsibility. If administrators understand the meaning of health, its relationship in the educational process and the major aims and objectives of the school health program, the first and most important step toward a successful program has been taken.

Four major responsibilities of the school administrator are

Planning
Organizing
Directing
Staffing

General responsibilities include

A. Leadership and guidance in the development of a total school health program.

B. Participation in the formulation of policies, standards and objectives of the program.

C. Budgetary provision for staff, facilities and equipment.

D. Employment of medical and nursing personnel with specialized preparation. Every effort should be made to employ physicians in general practice or pediatrics with special interest in school health and child care. Adequate remuneration and contractual agreements to insure job stability and incentive for well-trained physicians should be encouraged.

E. Delegation of responsibility to appropriate school personnel with assurance of administrative support. Those to whom such leadership is delegated must be informed as to the nature and limitations of their authority.

F. Establishment of priorities for duties of the nurse and physician which will eliminate procedures of questionable value and will allow for those functions which will make the greatest contribution to the health needs of each student.

G. Development of standards governing the efficient use and handling of cumulative health records including their transfer with the child from school to school.

H. Assistance in planning and making provisions for in-service health education for school personnel.

I. Provisions for a safe and healthful school environment for school and staff.

J. Sensitivity to the importance of creating an atmosphere which will foster the development of emotional and social adjustment of the students.

K. An administrative program which makes a sincere effort to meet the physical, mental and emotional health needs of both teachers and children.

L. Promotion of utilization of health services as a means of direct and indirect health education.

M. Promotion of better understanding and coordination of the school program with the total health needs and resources of the community.

N. Establishment of a continuing and well-integrated health education curriculum to meet the growing needs of the student in all areas of development.

In summary, the school administrator is a key person in the development of the school health program. His interest, coöperation and active participation are essential to the effective functioning of a program which will utilize every opportunity to help children and adults develop the understanding, attitudes, skills and habits important to living healthfully.

RESPONSIBILITIES OF THE SCHOOL PHYSICIAN

For standards to be operationally effective, an understanding of the role of the physician in schools is required. The primary responsibility for the total health needs of the child rests with the family and the child's own physician. Where this ideal cannot be attained community resources must be sought. While the pupil is under the jurisdiction of the school, the school physician has a responsibility for his health and safety. Although designated as a *"Medical Inspector"*, he functions as a school medical advisor and resource person to the superintendent, principal, teachers, school nurse and other members of the school health "team", in respect to the promotion of sound health, the prevention or detection of ill health and communicable disease, school hygiene and sanitation, and the development of general school health policies.

In brief the school physician's duties and responsibilities require that he promote to the fullest extent of his interest and training the development of school health services and health education programs in all ways to assure that every child makes maximum use of his physical, intellectual, emotional and social potentialities and opportunities for optimal growth through education.

The following are some of the specific activities of the school physician:

1. Health appraisal of pupils and school personnel

A. Pupils

1. A comprehensive health evaluation is recommended by the school physician with the assistance of the school nurse at regular intervals throughout the pupil's school career.

It must be emphasized that the cursory and incomplete physical examination of large numbers of children unfamiliar to the school physician is wasteful and a disservice to the pupil, his parents, the physician and the school. Studies have found them unproductive and only infrequently detect defects not previously aware of by the parents or personal physician. Such time consuming examinations routinely performed prevent the school physician from effectively assuming his proper duties and making a worthwhile contribution as medical advisor and consultant in essential areas of school health. Parents also assume that a proper examination has been done at school; they therefore may not take the responsibility of obtaining a periodic examination from the pupil's physician even when able to do so and the child's health supervision is jeopardized.

An adequate health examination and report submitted by the child's physician must represent the foundation for the pupil's school health record as well as for an accurate appraisal by the school health team.

In underprivileged communities or with indigent children, especially in the elementary grades, a thorough physical examination may be performed by the school physician with the parent's permission, presence and assistance if possible. In order to assure a meaningful examination by the school physician adequate provision for the necessary time and facilities must be arranged by the school district. Available community child health centers or clinics may also be used if more feasible and the completed health forms returned to school. It must be recognized that pupil examinations must be tailored to suit the socio-economic and environmental factors involved in any given school district, rather than follow a set pattern.

In any event, whether the health appraisal and care of each pupil is rendered privately or through school health services or community resources, it must be comprehensive, coordinated and as free of fragmentation or duplication as possible.

2. The school physician is responsible for providing the following additional physical evaluations and special examinations. A written communication from the child's personal physician or treatment facility should also be obtained as indicated.

(a) Pupils referred by the school nurse or principal, for special health problems.

(b) Upon the request of the school nurse or principal, for the determination of the physical fitness of a pupil for physical education and school attendance.

(c) The granting of certificates of physical unfitness of any pupil to receive vaccination, where such unfitness has been determined by him.

(d) New entrants in the school.

(e) Pupils classified as physically handicapped; these receive annual examinations.

(f) Pupils being referred to a Child Study Team or a consultant psychiatrist. These are examined by the school physician in respect to possible physical components involved in the deviant behavior.

(g) Upon the request of the school nurse or principal, for emergency calls in respect to suspected communicable disease.

(h) Upon the request of the school nurse or the principal, the school physician is available for all emergency cases requiring first aid and an examination for possible injuries.

B. Candidates for Competitive Athletic Teams

1. Before each sport season, candidates for a place on a school athletic squad are given a qualifying physical examination either by the school physician or team physician. The healthy athlete would require only one complete qualifying examination each academic year; a screening evaluation however should be made before each individual sport season with a review of injuries or illness which may have occurred during participation or subsequent to the previous sport.

A simple health history and examination form to be completed by his own physician is requested of each candidate each school year with particular reference to contact or strenuous sports activity and should include the recommendations and signed permission of his physician.

These examinations should give special attention to the cardiovascular system, previous head, back and musculo-skeletal injuries and especially physical fitness, physique and developmental readiness for the sport selected.

2. Attendance of a physician should be provided for all interscholastic games of contact sports such as football for emergency examinations and care. "Home and home" physician coverage may be arranged for "away" contests.

Medical attention must be also readily available for scrimmage and practice sessions. Coaches, trainers and special assistants with an adequate knowledge of first aid and emergency care trained by the school physician or other qualified personnel is highly recommended.

C. School Employees

The school physician has a responsibility for the health appraisal of all school employees as follows (See N.J. 18A:16-2)

1. New employees, including the use of the intradermal tuberculin test and arrangements for a chest X-ray of positive reactors.

2. Special consideration to employees in critical areas such as bus drivers and other special situations concerning physical fitness, mental illness, and vision.

3. Evaluation of employees returning from absence due to prolonged or serious illness.

In all instances, it is recommended that the employee's personal physician submit to the school district an appropriate certificate of good health and examination form for review by the school physician.

D. Working Papers

The school physician shall complete a physical fitness certificate for those pupils seeking working papers who have attended school in the district he is responsible. The pupil's school health record usually provides adequate information for this certification; additional examination may be performed if necessary.

2. Relationship to School Personnel

A. School Nurse

1. The school physician directs the professional duties or activities of the school nurse, and compiles and issues regulations governing professional techniques, the conduct of inspections or tests, and the administration of any treatment. (Ref: State Board Rules, pursuant to N.J.S.A. 18A: 40-1)

2. A close working relationship is essential for the effective implementation of all school health services. The school nurse maintains proper liaison between the school physician and the school administration, teachers and student body as well as the public health and medical community in the school district in matters of school health.

3. The school physician assists and supports the school nurse in the initiation of health career clubs such as future nurses and physicians. (As well as weight-control groups).

4. The school physician assists the school nurse in developing emergency and first aid procedures.

B. Teachers

1. Adequate lines of communication should be maintained between the classroom teacher, the guidance counselor, and the school physician concerning children not only with physical handcaps but those with

deviant behavior and learning problems. Appropriate discussions regarding proper and cooperative management is advisable.

2. In-service training programs should be initiated with the school physician in the newer aspects of child care and the behavioral sciences relating to teaching practices, as well as in sensitive areas of family life, physiological growth, maturation and child guidance.

C. Administrators

1. The interested school physician can provide invaluable support and assistance to the principal and the local Board of Education in the periodic review and maintenance of high standards of school health practices.

2. The School Health Council must have medical representation by the school physician to function effectively. He can not only assist in the proper understanding of existing and new regulations concerning the physical needs of the pupils but also cultural and social problems of significant influence on the student body, especially at the intermediate and secondary level.

3. Curriculum Planning

A. Health Education

1. The school physician should assist in the development of a sound and well-integrated health education program. Because of his education and experience he can best serve in consultation with the nurses, physical education instructors or special teachers primarily charged with this program. In-service training or meetings for discussion should be planned for the proper consideration of subject matter especially in such areas as family relationships, human biology, drug abuse, and mental health.

2. The school physician should review the films, literature, and texts assigned to the class for their authenticity as well as appropriateness for the grade level and for that particular community. The advisability of "Crash Programs" or lectures on such topics as venereal disease and narcotic addiction by the school physician or by others, is questionable when not well-integrated into the class work and do not permit prior orientation and subsequent ventilation of ideas.

B. Physical Education

1. The school physician should assess the physical education and fitness program and its conformity to acceptable standards of

physiological growth, safety and functional importance and a meaningful experience for the student.

2. He should encourage the active intramural and extra-curricular participation of all pupils in sports activities particularly those that will carry over into later life such as swimming, tennis, hiking and camping. A proper balance must be reached with the more spectacular interscholastic athletic program in the secondary school. Highly competitive contact sports are not recommended at the elementary school level.

3. He should stimulate and supervise physical education programs adapted for the exceptional child or those in special education classes and schools for the handicapped. In addition he should examine those special programs designed to enhance the learning potential of pupils with possible perceptual, visual-motor or reading disabilities in order to assure they are based on sound and proven neurological concepts.

A. Participation in Child Study Team

A. The school physician acts as the primary medical consultant on the Child Study Team in the identification and classification of all categories of the handicapped school child. In most instances a comprehensive medical appraisal is the basis for an accurate classification. His evaluation is based on reports from the child's personal physician or other clinical facilities involved in the care of the child as well as his physical and neurological examination if necessary. (Refer to "Recommendations for the School Physician in Relation to Special Education Services for Handicapped Pupils, New Jersey State Department of Education, February, 1967)

B. The school physician has an excellent opportunity as well as a responsibility to broaden his background and understanding of the diagnostic testing and techniques employed by the psychologist, the learning disability specialist and other members of the team. In turn, his training provides a source of information of newer aspects of medical research to supplement their own areas of special concern. This professional rapport assures a high level of interdisciplinary competence of the Child Study Team.

C. The school physician attends conferences of the Child Study Team. He can interpret the clinical findings and reports of any medical facility or specialist and offer meaningful and efficient guidance concerning the need for sophisticated tests and consultation for the child under study.

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D. The school physician can make a practical contribution to the programming of the child requiring special education within the available resources of the school district by the effective personal communication with the child's family physician and if necessary, his parents.

5. *Public Health*

A. The school physician complies with the rules and regulations of the local board of health and the State Department of Health, which relate to the sanitation of public grounds and building and to the prevention of communicable diseases, and may make suggestions as needed to the district board of education on the sanitary operation and maintenance of such grounds, buildings and equipment.

B. The school physician familiarizes teachers at such times as may be requested by the district board of education concerning the methods employed to detect the first signs of communicable disease, the recognized measures for the promotion of health, safety, and the prevention of disease.

C. He coordinates the efforts of community health resources, the local Department of Health, and the school health services in all areas of mutual concern such as tuberculosis control and preschool immunization and screening programs. Adequate communication with public health nursing and social service agencies should be maintained in family related problems as well as the follow-up care of physical disabilities in the school child.

D. Community programs in automobile safety and fire prevention in cooperation with local police and fire departments may require the assistance of the school physician.

6. *Community Relations*

The school physician takes opportunity to interpret the policies and programs of health services, health education and health environment to community groups and organizations and to local or county component medical societies, and in turn to familiarize the school administration with new developments and community interest and opinion in medical and health matters.

7. *Continuing Education*

The school physician should endeavor to join with other interested physicians in such organizations as the New Jersey Association for

School Physicians, Education Associations and The American School Health Association.

SCHOOL NURSING

Over sixty years ago, a new dimension in the practice of nursing became a reality with the assignment of the nurse to school health work. Inspections of schools by doctors are as old as 1842 in France and 1874 in Belgium but school nursing had its beginning in 1892 when the London School Board realized that valuable school time was lost by children owing to minor ailments. It applied for aid to the Metropolitan Nursing Association and in 1893 one nurse started school visiting.

In 1898 the London School Nurses' Society began with five nurses. In 1900 the London School Board appointed one nurse familiarly known as the "ringworm nurse." In 1902 a nurse was assigned to the New York schools primarily for the purpose of assisting in the return of pupils who were absent because of illness. Subsequently, school nursing services were extended to the promotion of more sanitary school living conditions, detection and control of communicable disease, identifying children with remedial defects and getting these defects corrected. During this era, the concept of school nursing was that of a preventive program dealing with problems within narrow limitations of a physical nature.

From this narrow sphere of activity has converged a much more complex and divergent school health program with the concurrent growth in the responsibilities and involvement of the nurse as an integral part of the educational team. The number of school nurses has more than tripled in the past twenty years. The specialty of school nursing has grown more rapidly than any other field or specialty within the broad area of public health nursing. This area of nursing has grown so fast that there have been and still are confusion and lack of understanding among nurses and school administrators regarding the expanding role of the nurse in the total school program.

Such confusion is not unwarranted. As schools continue to expand pupil-personnel services and to add specialists in all areas of child guidance the roles of each of these specialists become more and more difficult to distinguish. They are beginning to overlap and to mingle until like a camera out of focus the images begin to blur.

This expansion has resulted in a new interest being focused on the school health program. We have become aware that school health

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services based on routines and procedures developed twenty or more years ago are not applicable to today's fast changing society. Health needs of children change with the socioeconomic advances of society, with progress in medical knowledge and with increased understanding of human behavior, growth and development.

With these changes the relationship of all who contribute to the needs of children and youth will be one of the most crucial issues ahead. The "team approach" as specified in the Rules and Regulstions pursuant to Chapter 29 Laws of 1966 and succeeding legislation has demonstrated the value in a change from isolated segments to the coordination of all effort directed toward the whole child.

This new approach demands that the focus be on the *individual* and *his* problems rather than on the health of the entire group. In working to help solve individual problems the school nurse as a health specialist has a distinct service to perform within the framework of the team.

The school nurse is usually the one specialist who training is such that she sees the child and his health problems as they relate one to the other. She may be the one discipline who is involved with a corps of specialists, i.e. physicians, counselors, social workers, teachers, family, administrators and community resources. She has much to offer in the team efforts for critical inquiry, decision making and therapeutic action needed to solve or alleviate individual problems of the troubled child.

Dr. J. Kirk Seaton, former Director of Office of Psychosocial Studies, in a speech to school nurses suggests the following ways in which the nurse might perform more effectively:

1. **Pre-School Children.**

Early identification of defects, particularly defects of communication. If the pre-school child with defects is not reached before he enters school he may be unidentified for several years. His educational progress may be affected detrimentally to the point where he cannot catch up thereby creating a potential drop out.

Through working with public health nurses and community groups these children may be identified and remedical action started at a much earlier and more easily corrected stage.

2. **Screening for Sensory Defects Leading to Learning Disabilities.**

When the nurse makes a referral to correct defects in hearing or vision, she is also exerting a positive influence on the psychological element of the child.

3. **Observing for Signs Which May be a Clue as to Why a Child Doesn't Learn.**

Are there Central Nervous System involvements? Is there something unusual about the way in which the child walks or runs? Momentary lapse of inattention or petite mal? Obesity, acne, too short, too tall – do these affect learning because of emotional effects? How can they be helped?

4. **Health Room Visits** – are the complaints psychosomatic? Is it:

Family disorganization?

Escape from the classroom, gym, art?

5. **Referral.**

a. Gathering information. How often – when – is there a pattern of behavior?

b. Counseling and sharing information with all those who have an interest in the child – including school personnel, home and community agencies.

These suggestions of Dr. Seaton are merely signposts for the paths ahead. There are questions of priorities in program planning and there are problems related to understanding, team-work and fuller utilization of professional skills which each discipline has to offer.

School nursing has made much progress since 1900 and the appointment of a "ringworm nurse." Today, our primary concern is not where we have been but how may we move effectively from where we are to the place of professional competence which today's society demands of us if we are to meet the needs of youth.

This concern about the direction of school nursing services has been explored in a study carried out at Teachers College, Columbia University.[1] The observations from this study indicate that as a specially prepared resource person in health, the nurse has knowledge and skills different from those of other staff members. Because of her role, she is able to follow a child and often a family during the school life of that child. She cares for the child during a period when he can be considered to be in a state of vulnerability because of his age and the various influences that constantly impinge upon him. Knowledge of a child's state of vulnerability can assist the nurse to be helpful to him as she provides emotional support in a variety of ways. This knowledge can also be used to plan total health care for children and to establish priorities for nursing services. As school nurses identify and give priority to the vulnerable status of children, they can aid in the development of health programs which focus on primary prevention in the area of mental health, and also minimize untoward effects of stress.

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[1] Stobo, Elizabeth and others. *The Nurse in the Elementary School: Promotion of Mental Health.* New York: Teachers College, Columbia University, 1968

The changing role of the school nurse is reflected in the following statement of school nurse-teacher responsibilities which accompanies certification requirements for school nurse teachers in New York State.[1]

The statement reads:

Subject to the direction and supervision of the superintendent of schools, the school nurse-teacher works with other school health and pupil personnel workers in a program designed to promote, protect and maintain the health of all pupils. The school nurse-teacher has a major role in planning, with representatives of the school staff and appropriate community agencies, for a health service program to carry out the school's responsibility in meeting the health needs of pupils. The nurse-teacher serves as a health consultant to administrators, teachers, and other staff members in regard to all maters affecting health of pupils and school personnel.

Representative school nurse-teacher responsibilities include:

1. Assisting in conduct of periodic examination and screening procedures to determine health status of pupils, with such procedures planned to constitute an integral part of the curriculum in health education

2. Counseling with pupils and parents to interpret health problems, to assist parents in utilization of professional resources for diagnosis and treatment, to interpret professional recommendations

3. Conferring with teachers and other school personnel to share and interpret pupil health problems and to develop plans for modifications of the school program

4. Assisting teachers in planning, coordinating, and evaluating health education activities; serving as a consultant in health instruction; assisting in evaluation of health instruction materials

5. Assisting in planning and maintaining a safe and healthful school environment, including the establishment and implementation of emergency care procedures

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[1] The University of the State of New York. Unpublished statement of school nurse-teacher responsibilities. Albany, N.Y.: The State Educational Department, 1968.

6. Conferring with representatives of community agencies in matters pertaining to family and community health

7. Providing inservice health education for teachers and other school staff

8. Evaluating outcomes of school health service program

New Jersey is one of a growing number of states where recognition of the contribution made by school nurses is acknowledged by having such services made mandatory. Every board of education shall employ a school nurse "except any board of education furnishing nursing services under a contract pursuant to P.L. 1956, Chapter 233, Section," was signed into law by Governor Hughes, January 4, 1966.

The fact that the employment of a nurse to serve in the schools was no longer allowed to be permissive is a testimonial to the recognition of her contribution to the total educational program.

The nurse as a member of the school staff occupies a position similar to that of any other certificated professional employee. She is expected to serve as a consultant and an advisor upon matters which relate to mental, emotional or physical health, to attend teachers' meetings of general interest, and to serve on health or guidance committees.

Arrangements should be made for the nurse to attend professional and educational conferences and meetings. This is an important type of in-service education and a professional responsibility.

An adequate allocation of time other than after school hours is needed for home visits and other community contacts. A portion of the school day justifiably should be scheduled for such work. Without this provision this important function cannot be adequately performed.

Methods for transporting pupils from school to home or clinics should be determined and observed. Except in extreme emergencies transportation of pupils should be done by someone other than the nurse.

A contract of work should be agreed to and signed by the school authority and the nurse. Major duties to be performed, length of working year, minimum daily hours of work, methods of reporting on and off duty and absences, and the length of vacation together with other pertinent considerations, should be clearly understood.

Adequate reimbursement for expenses incurred by travel on school business should be included in the contract with the nurse.

Approved school nursing functions have been developed by a committee of school nurses from most of the states in this country. Over 1,000 nurses contributed to these recommendations. All services in the list are approved functions for a nurse serving a school. Since the completed outline represents authoritative opinion as to the responsibilities and duties of the nurse working in schools, it is included in this publication. Few nurses are able to implement the entire proposed outline. It will, however, serve as a guide to help nurses select their duties. The following outline is quoted from the article *Recommended Policies and Practices for School Nursing,* Journal of School Health.

SPECIFIC AREAS OF NURSING RESPONSIBILITY FOR SCHOOL HEALTH*

The school nurse works as a member of the school staff under the administrative direction of the principal of the school to which she is assigned. She is responsible to the nursing profession for those things which are nursing functions, keeping in mind the fact that the school administrator has the responsibility for the total school program.

A. Health Appraisal.

The school nurse works with administrators and all other school personnel, local physicians, dentists, community health agencies, social agencies, and parents in defining the objectives for and the procedures to be followed in making health appraisals. She confers with teachers in selecting children for health appraisals and helps teachers prepare children for health appraisals so as to make them meaningful to the children. She interprets the results of health appraisals to school personnel and parents.

1. Medical and Dental Examinations.

a. Assists in planning and arranging schedules for the physician, dentist and dental hygienist at school.

b. May assist with the examination.

c. Assists with working out a program to utilize services of private doctors, dentists and clinics.

2. Vision and Hearing Screening.

a. Assists in arranging for vision and hearing screenings for all school children.

b. Routine vision and hearing screening of all children, and special screenings when indicated.

3. Height and weight measurements. Assists in arranging periodic weighing and measuring of school children.

4. Follow Through.

a. Assists parents to obtain needed corrective care where indicated.

b. Assists teachers in making adjustments in children's programs, and seating arrangements, etc., when needed.

B. Emergency Care of Accidents or Illness at School.

1. Assists in setting up policies for caring for students who are injured or who become ill at school.

2. Renders first aid to injured or ill students.

3. Assists in selecting first aid supplies and secures written instructions for the care of sick or injured students.

C. Communicable Disease Control.

1. Participants in the development of methods to carry out policies and procedures for the control of communicable disease within the school and in the interpretation of these policies to school personnel and parents.

2. Assists school personnel in screening for communicable diseases.

3. Assists in arranging for the isolation of ill children who are to be excluded.

4. Inspects children and school personnel when referred for suspected communicable disease and recommends exclusion and readmission in accordance with school policy.

5. Assumes responsibility for the organization of the immunization program if performed within the school.

6. Interprets the scope and significance of immunization programs to school personnel, students and parents.

D. Growth, Development and Nutrition.

1. Understands the growth characteristics of children and applies this knowledge when dealing with pupils and their problems.

2. Recognizes and calls attention of school physician to deviations from normal growth patterns of children.

3. Cooperates with school personnel in helping children overcome handicap of over or underweight, and counsels with pupils and parents under direction of school physician.

4. Understands basic program of good nutrition and participates in a nutrition education program.

E. Guidance and Counseling.

1. Confers with pupils and/or their parents regarding health

problems and obtains pertinent health history from parents.

2. Confers with school personnel regarding health problems of pupils.

3. Upon request, confers with school personnel regarding their own health problems.

F. Exclusions and Readmissions for Health Reasons.

1. Participates in establishing policies and procedures for excluding and readmitting students to school.

2. Recommends exclusion and readmission according to school policy.

G. Exceptional Children.

1. Participates in planning programs for exceptional children.

2. Interprets to teachers recommendations for adapting program for handicapped children.

3. Helps children to accept and to learn to live within their physical limitations.

4. Works with physical education teachers in program planning for children on restricted activity.

5. Assists in case finding and referral for special programs.

6. Keeps careful records on all handicapped children.

H. Home Visitations.

1. Serves as contact between home and school on health problems.

2. Interprets to school personnel the situation in the home as it affects the students' school program.

3. Counsels with parents about the health of their children and their adjustment to the school program.

4. Recognizes that the total family health status is important to the welfare of the school child.

I. Rest and Relaxation.

1. Participates in the planning of rest facilities for students.

2. Participates in planning the school day to allow for periods of rest and relaxation.

3. Interprets to school personnel the need for rest periods for certain children.

J. Cooperation with Community Agencies.

1. Familiarizes herself with the work done by all community agencies, voluntary and official.

2. Is active in community organizations which contribute to

community health and welfare.

3. Cooperates with other organizations to promote the health awareness of the community.

K. Records.

1. Participates in the selection and use of health records.

2. Keeps accurate, clear records of the health of school children.

3. Helps school personnel to interpret data recorded on health records and to use the records as tools in the guidance of pupils.

4. Utilizing record material, continually evaluates total school health program.

L. Mental Health.

1. Participates in planning a school program which is conducive to good mental health.

2. Recognizes signs of deviation from good mental health and refers pupil for professional care when indicated.

3. Helps parents obtain treatment for their children when needed. Informs parents of available resources when needed.

M. Relation to Health Instruction.

1. May teach home nursing in the classroom, or routine health classes if she has a teacher's certificate, or as a nurse may be responsible, with the help of the teacher, for single units of classroom instruction.

2. Serves as a resource person to all school personnel in matters of health education.

3. Suggests or procures suitable health materials for class instructions or bulletin board use.

4. Arranges with the principal to hold teacher-nurse conferences in her capacity as consultant or advisor.

a. Interprets needs and health problems of children through her knowledge of the individual children and their families.

b. Assists the teacher to interpret to children the procedures and purposes of medical and dental examinations, screening procedures, and measures which may be adopted in the communicable disease control or first aid and safety program.

c. Suggests materials to be taught at the same time as a dental inspection or vision screening or hearing testing program is being carried on so that the instruction and experience will be meaningful to the child.

5. Assists teachers when special community health programs are carried on.

6. Assists with the in-service education of teachers through

workshops and institutes or through individual conferences.

7. Works with school personnel on health problems of children.

8. Gives health guidance in all her contacts with individuals and groups in the school and community. (Even such a simple procedure as supplying a band-aid can be used to teach a child the importance and method of caring for minor wounds. Conferences with parents at home or at school are opportunities for instruction in health matters.)

9. May develop a student-aide program at the secondary level in accordance with school policy.

N. Environmental Health

1. Keeps well informed of the standards and laws for a healthful and safe school plant.

2. Confers with school personnel and students in the maintenance of a safe, clean and healthful school and community.

3. Considers factors influencing the physical and emotional health of the school personnel as well as that of the students and recommends and suggests improvements affecting those factors.

4. Aids in in-service health education for bus drivers, custodians, cafeteria workers and teachers to bring their knowledge up-to-date on such matters as school sanitation, communicable disease control, first aid, hazards of transportation, school safety and civil defense.

THE PREPARATION OF THE SCHOOL NURSE

The preparation of a professional person for a chosen type of work should be based upon specific functions that are required for the attainment of pre-established goals in the particular field of interest.

The nurse in the school is in a unique position. The uniqueness of her services in and for a school lies not so much in what she does, but how she does it, and in her understanding of the objectives and goals of a school health program.

The nurse working in the school gives remarkably little service to the children or the staff which can be identified as "actual nursing." Her contribution to the school program is of particular value because of the knowledge and judgment she has developed through her nursing education and professional experience. In order to serve successfully as a member of the educational team, then obviously, the nurse in the school must have preparation beyond that offered by the basic program in nursing and in some instances beyond the basic nursing degree program.

The nurse must understand the educational purposes of the school. In addition to skills and understanding common to all public health nurses she needs to be familiar with the total school program, principles of school organization and administration, counseling techniques and procedures for helping teachers in supervising the health of children.

The school nurse serves as an educator as she shares in carrying out the school's responsibility for a program of health services, health education and healthful school living.

Typical examples of the kinds of information which are used in working with school age children are:

1. Child growth and development.
2. Special needs and educational plans for exceptional children.
3. Fundamentals of food, nutrition, rest and exercise.
4. Fundamentals of mental, emotional and social health.
5. Scientific and practical knowledge of lighting, heating and ventilation.
6. Healthful and safe school environment.
7. Public health nursing and community health.
8. Methods of teaching and curriculum development.

Preparation for school nursing represents a synthesis of offerings from several disciplines including education, nursing, public health, the natural and behavioral sciences and sociology.

Certification requirements have been established in many states in an attempt to define minimum standards of educational preparation for the school nurse.

The Office of Teacher Education and Certification has developed approved programs in school nurse certification in the following colleges and universities in New Jersey:

Fairleigh Dickinson University
Jersey City State College
Glassboro State College
Seton Hall University
Trenton State College

The courses are designed to satisfy requirements for school nurse certification. Other colleges will probably establish programs as the need increases or as evidence develops for more programs to be established.

PROFESSIONAL ORGANIZATIONS AND THE SCHOOL NURSE

Most professions today consist of several fields which cluster around and move out from a central body of mutual concerns. The nursing profession is a classical example of such accelerated widening of interests and activities. The growth of the profession and its interrelationships with other disciplines and areas of specialization has resulted in confusion and question as to what professional organizations are to be supported.

Regardless of where she works, by whom she is employed, or the scope of her responsibilities, the professional nurse serving the school has but one objective — to give the best service possible.

Participation in professional organizations is one of the most practical means for a nurse to develop skills in human relations and competence in leadership.

The school nurse has a unique opportunity to serve two professions at the same time — nursing and teaching. Because of the dual responsibilities, she becomes obligated to give consideration to membership in professional organizations in both fields.

The following associations are among those to which membership should be given consideration. Each has a concern with the development of standards and qualifications for personnel who work in schools.

American Nurses' Association
National League for Nursing
American School Health Association
New Jersey State School Nurses' Association
County School Nurses' Association
Educational Associations

Contributions made by these various associations have been effective in raising standards of school health services. Without their support and guidance, it is doubtful that the school nurses in New Jersey would have continued to grow in number, in education and in recognition that she is part of and has a valuable contribution to make to the educational team.

SCHOOL NURSE DRESS

"The nurse, like the physician, has a different type of task when she works within the framework of the school, for it is not the clinical situation to which she has been accustomed in her hospital experiences. It is a new kind of experience, one with children, to which the nurse must bring warmth, acceptance, and understanding. To the teacher she must be a source of information and guidance. To the parent she must be a friendly counselor — cognizant of community resources, sympathetic with family problems, and an interpreter par excellence of the child's needs as revealed by medical examinations and school behavior."[1]

The functions which are involved in school nursing are of a diverse nature. They are usually so far removed from procedures which are necessary in the nursing care of the hospital patient that the traditional uniform of the nurse is inappropriate in most instances in the public school. The white uniform has always been a symbol for care of the ill in a clean, sanitary setting. Since it is school policy to send sick children home as soon as possible, a white uniform is not needed.

The wearing of a white uniform is particularly questionable in those districts where the nurse is called upon to transport students, either to their homes or to clinics, or to travel from one school to another.

Nurses should give serious consideration to their personal appearance, if they are to function effectively with today's children. The sterile, white (too often tattletale grey) hospital uniform is not conducive to establishing a rapport with the young person who desperately needs a non-judgmental ear to listen to his concerns and worries about emotional and physical difficulties.

Style and appearance are important in the classroom and even more so in the one-to-one counseling situation. The young person who is in real need for help in guidance for problems relating to his physical and emotional being will react more positibely toward an attractive, well-dressed person than one who presents the austere barrier of an antiseptic white, sick room atmosphere.

The nurse should not be a reminder of poor health or injury and restricted physical activity but should use all her resources to present a warm, attractive personality who will do all that is possible to help the disturbed young person seek the best means possible to achieve health and physical fitness.

NURSE-PUPIL RATIO

The employment of the school nurse usually is the first step in building a staff for health services. Recommendations of the number of nurses needed for the school population varies considerably and is dependent upon various factors.

An excerpt from "Recommended Policies and Practices for School

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[1] World Health Organization. Expert Committee on School Health Services.

Nursing," which was compiled by a national committee of school nurses for the American School Health Association, states:

Pupil Load of the School Nurse

The number of pupils one nurse can serve in a school district should be established only after careful evaluation of the following factors as they exist in the specific school situation.

A. The scope of the School Health Program.

1. Health needs of pupils.
2. Availability of related school personnel, such as physicians, dentists, dental hygienists, school social workers, counselors, visiting teachers, attendance officers, health coordinators, school psychologists, clerical assistants and volunteer workers.
3. Provision for the services of exceptional children.
4. Time expected to be spent by nurse in participating in community programs for health.

B. The physical factors within the school plant and the community:

1. Extent of the school's geographic area.
2. Transportation and communication facilities.
3. Number and type of school buildings.
4. Existence of school and community health facilities.

C. The existing socio-economic factors:

1. Stability and growth of the population.
2. Stability within the family groups.
3. Increase and turnover in school personnel.
4. Employment conditions within the community.
5. Education and health consciousness of the parents.

In New Jersey returns from a questionnaire to school nurses indicated that the greatest number of school nurses were employed on the basis of 500-999. The second largest was that of 1000-1499. Observations and evaluations of effective comprehensive health programs indicate that a well-qualified full-time nurse can render satisfactory service to pupils when her pupil load falls within the 700-1000 range.

This ratio appears to be particularly appropriate when consideration is given to recent legislation and recommendations concerning the role of the school nurse as a member of the Child Study Team.

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SCHOOL NURSE SUPERVISION

By law, this is the responsibility of the local board of education, the school administrator and the school physician. Coordinated endeavor is not precluded, but the responsibility of fitting health services into the total school situation is the responsibility of the school administrator. The school nurse must work according to policies approved by the school physician and school administration and adopted by the board of education. (N.J.S.A. 18A:40-3.1)

The supervisor or school nurse coordinator shall perform her functions according to the provisions of the foregoing paragraph. Where more than one nurse is employed, it is desirable for one nurse to serve as coordinator of school nursing. Part time supervision should be provided for a staff under five nurses and full time with a staff of eight or more.

Responsibilities of the school nurse supervisor should include the following functions:

a. Planning, preparation, organization and implementation of all health service programs.

b. Interviewing and selection of all staff nurses.

c. Orientation of new staff nurses.

d. Provision for new staff nurses and substitute nurses of an observation field experience in school nursing.

e. Regularly scheduled staff meetings with a prepared agenda which would include items such as:

- discussions of school nursing policies, objectives, professional standards, techniques and procedures; plans, programs and schedules of work; of specific school health problems; specific school nursing problems and problems general to health education and public health.
- reports of special studies and surveys by members of staff; of national, state and local meetings and conferences attended; of various phases of the nurses' work.
- reviews of health and nursing books, bulletins, journal articles, etc.
- demonstrations of techniques and practical procedures, e.g. vision testing and orthoptics.
- securing speakers on special subjects.
- preparation of materials, circulars, bulletins, visual materials — graphs, etc.
- arranging for the showing of professional school health films.

- professional reading and reference materials.
- exhibits.

f. Promoting effective communication and interpersonal relationships with other members of the faculty.

g. Promoting participation by all nurses in child study team evaluation and placement.

h. Participation in development of records and forms used in recording health data.

i. Evaluation of school health program and recommendation for change as needed.

j. Promotion of close cooperation with community health agencies and contacts with parents.

These are but a few of the activities which are to be assumed by the supervisor. Good supervision helps the staff nurse to keep informed of the psychological, scientific and education advances that are occuring so rapidly.

The nurse supervisor does not replace or supercede members of the school staff who are administratively responsible for school health services. Her responsibility is primarily to work cooperatively with those in authority and to provide an essential connection between the staff nurses and the various school and community representatives who are concerned with the health of children.

The discerning supervisor is in a strategic position to make an assessment of the total health program — to eliminate that which is superfluous and to identify those factors in need of change. With the vast social, environmental and other changes occurring in today's world, it is imperative that identification of needs and necessary preventive measures be of high priority in the concept and performance of one to whom the responsibility of supervision of health programming for school children is given.

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NATIONAL SCHOOL NURSE ORGANIZATIONS

National Council For School Nurses. School Health Division. American Association For Health, Physical Education and Recreation (NEA) 1201 Sixteenth St. N.W. Washington D.C. 20036

N. E. A. Department of School Nurses, 1201 Sixteenth St., N.W. Washington, D.C. 20036

PART II

HEALTH APPRAISAL AND MEDICAL EXAMINATION

The law provides that:

"The medical inspector, or the nurse under the immediate direction of the medical inspector, shall examine every pupil to learn whether any physical defect exists, or in lieu thereof the medical inspector may accept the report of such an examination by a physician licensed to practice medicine and surgery within the State." 18A:40-4 (amended 1969)

The primary responsibility for the total health needs of the child rests with the family and the family physician. While the pupil is under the jurisdiction of the school, the school physician has a responsibility for his total health and safety. The school physician is responsible for conducting a medical examination of the whole child.

The medical examinations of pupils by the school physician are screening examinations only. They are not intended to replace the medical examination made by the family physician. They should, however, be recognized as constructive learning situations. Defects found by the school physician are reported to the school authorities and to parents so that the latter may secure the appropriate professional care.

Pupil health appraisal is functional health education. It provides an ideal situation for motivation and education in the area of personal health. Although it is a means to an end, the health appraisal is perhaps the most important of all school health activities as a continuing process, including health guidance.

Appraisal of health denotes a positive approach in which major emphasis is placed upon the health assets of a pupil. Deviations and deficiencies are appraised in terms of the degree to which they obstruct or interfere with effective learning and enjoyable living.

Among the fundamental educational objectives are:

1. Develop in the pupil an understanding interest in his health status.

2. Establish a life-long practice of having one's health evaluated at regular intervals.

3. Develop in each pupil an appreciation of the value of professional services, methods and techniques.

By law, the school physician is licensed to practice in the state of New Jersey and a graduate of a school of medicine or osteopathy. In addition, he should have a thorough understanding of child health, developmental medicine and human behavior, and the child rearing process. He should have sufficient understanding of public health practice to deal with problems which may arise in institutions. This implies a comprehensive education and wide experience but is no different from the background to be expected for a physician who would provide a high standard of care for children under any circumstances.

Since the physician cannot be expert in all areas he is expected to call upon consultants as needed in such fields as orthopedics, psychiatry, psychology, dentistry, and others which may be required.

The first area of school health concern is the appraisal of child health, and the definition of optimum readiness to benefit from school, from the medical point of view.

The school physician will perform child health examinations as prescribed by law and regulations, except that wherever possible, he will arrange for these to be done by the child's personal physician. The school physician will, however, review and approve these examinations. These examinations should include both a medical history and physical examination as a basis for health appraisal.

Included within this examination should be a medical history which would include but be not limited to circumstances of pregnancy, labor, delivery and perinatal experience, significant diseases, accidents and surgery, a review of developmental milestones, a description of behavior and of innate temperamental patterns of reactivity, a review of the family history and health of siblings.

The physical examination shall include, but not be limited to, examination of the sense organs, neurological, musculoskeletal, cardiopulmonary and genitourinary, cutaneous and maxillo-facial structures.

The report of the health appraisal shall include but not be limited to (a) health problems found in need of further diagnoses and/or treatment, (b) physical, emotional and cognitive developmental status, (c) recommendations for planning a health program to attain a comprehensive optimal state of health.

Records of the health examination shall be kept in compliance with state rules and regulations, and shall be the basis for the planning of services, both for the individual child, and to be provided by the school system as a whole. The report shall be oriented so that it will indicate the child's readiness for his current educational process and the modifications which should be made in that process or in the child's state of health for him best to profit from his education.

It is important to realize that children whose problems arise as a result of either poverty, affectional deprivational or developmental disorders should be identified and aided as early in life as possible, and ideally, within the first three years. For this reason, it is recommended that the school shall join with community health resources for the purpose of early identification, diagnostic evaluation and provision of needed services and planning for the development of new programs. Every consideration will be given to early identification in the community of children with environmental or personal health problems which may result in difficulty in learning or in adjustment.

Parents whould be requested to attend during the examination of all children in the first six grades. In the absence of the parent, the nurse shall be present when a student is examined.

GROWTH AND DEVELOPMENT

Growth and development follow a predictable sequence but are unique for each individual. Each child's development is influenced by heredity, environment and personal practices. There are variations in social, emotional and physical maturity, as well as between sexes of the same age.

Children are interested in their growth and development and the changes found when height and weight are measured periodically. These serve as a basis for instruction relating to the factors that influence growth and maturation and furnish motivation for improvement of health practices.

Frequency of such evaluation should be determined by individual school population needs. Unless otherwise indicated, an annual check of physical growth should be sufficient. Comparison of measurements among children should be discouraged. Emphasis should be placed on the individuality of the child and on his present measurements in relation to previous measurements.

A child who shows an excessive gain, a weight loss, or failure to gain as expected, should be referred to the school physician or family physician, if necessary, for an interpretation of his changed height-weight relationship and any recommendations which may be indicated.

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VISUAL APPRAISAL

Visual Appraisal involves (1) observation for obvious defect and disease and (2) judging visual acuity with the use of testing procedures which give some measure of ability to see test objects at measured distances.

School appraisal is not a substitute for a professional eye examination – nor should a parent delay a professional examination until school age. All children should have a professional eye examination before he reaches his fourth birthday. The school appraisal may reveal the need for further evaluation, but does not in any manner intend to diagnose a visual defect.

Referrals should be made on those children who:

1. Have impaired visual acuity
2. Have simptoms which may suggest a visual problem.

Teacher observation is an important factor in screening for defects. Whenever the teacher observes any of the following signs, the child should be referred for an eye examination.

a. Crossed eye, "wandering" eye, "cast," even though not constant.

b. Excessive blinking, or squinting.

c. Red eyes or eyelids, or frequent styes.

d. Rubbing or wiping eyes frequently.

e. Apparent difficulty in seeing what is on the blackboard, or inability to see small detail in near vision or stumbling.

f. Persistent frowning, especially in reading.

g. Persistent reading difficulty, especially if there are signs suggestive of a possible ocular basis; e.g., word omission or repetition, transposition in the line, jumping lines, repeating lines or misplacement of a word to line above or below.

Whenever the teacher is in doubt, or whenever she observes any other eye condition she suspects may be a factor in the education of the child she should refer the child to the school physician, or to the school nurse, if the physician is not available, without waiting for routine screening tests.

If the child reports any of the following an eye examination is indicated:

a. Cannot see well.

b. Words, letters or lines "run together" or "jump."

c. Double vision.

d. Vision blurs (especially after period of reading).

e. Headache or other symptoms after work involving continuous near vision.

Children who fail in their studies or who in other ways fail to succeed in school life should be referred to the family physician even though the entire medical screening program (including the eye screening which is merely a part of it) yields negative results. Such children deserve individual detailed medical examination. It is then the responsibility of the family physician to arrange for any and all special investigations which may be required. These may include, among others, special psychiatric examination or laboratory tests.

Preparing Pupils for Vision Screening

Prior to vision testing children should be informed concerning the purpose of the test and the procedures to be followed. This is particularly important in kindergarten and lower elementary grades. A demonstration may be effective for these children. Attention should be given to children's questions and an effort should be made to give answers which can be comprehended at each grade level of understanding. Advantage should be taken of this opportunity to integrate health education by explaining how the eyes function, the relationship between light and sight or how lenses help improve the vision. Principles of eye safety can also be discussed at all grade levels.

Visual Acuity Tesking

The visual acuity test identifies most of the children requiring referral with relatively few errors. It is effectively done by the standard Snellen chart (letters or E characters) for use at a distance of 20 feet. A visual acuity test is actually the chief test in all test batteries and instruments which have been offered for school screening.

Procedure:

1. *Snellen.* The child should be seated 20 feet away from the chart. Instruct the child to keep both eyes open and cover the left eye with a small card or folded paper resting obliquely across the nose. Use fresh cover for each child.

Test the right eye first, then the left, then both eyes. If glasses are worn, test with glasses.

Begin with the 40-foot line. If this line is failed, start with the 200-foot line.

The standard for failure shall be inability to read 3 out of 5, or 4 out of 7 symbols with either eye on the 20/40 line in kindergarten through grade 3, and on the 20/3- line in grades 4 through 12. Children who fail the visual acuity test shall be referred for further examination.

2. *Plus Lens.* A test to detect hyperopia (farsightedness). The child should be seated 20 feet from the Snellen Chart. Both eyes should be open and tested together.

The standard for failure shall be the *ability* of the child to read 3 out of 5 or 4 out of 7 symbols on the 20/30 line with the lens in front of the eyes. Test with glasses, if worn.

Color Blindness

Simple color tests using multi-colored yarn or paper should be performed on entering school in kindergarten or first grades. Parents and teachers of most color blind children are not aware of this handicap. The color-vision-defective pupil is at a disadvantage in the present education system which utilizes color in teaching techniques. Unrecognized color blindness may have serious effects on a pupil's attitudes and performance.

Testing for color vision is recommended for all students before entrance to the junior high grades. There is no known authentic cure or treatment for this condition but the student and parent should be made aware of the fact that this deficiency exists. Children with this condition need to be aware of it when making vocational choices and when learning to drive. Both drivers and pedestrians need to distinguish red lights from green ones. Color tests need to be given with natural daylight illumination, but not direct sunlight.

Two color vision tests satisfactory for school use are the Hardy-Rand-Ritter Test (American Optical Co., Southbridge, Mass.) and the Ishihara Test (Takamine Overseas Corporation, 10 E. 40th St., New York). Directions must be followed carefully for reliable results.

Other Vision Tests

Several test patterns and devices have been developed for vision screening. The test to be used should be selected by the school's medical advisor. Consideration should be given to the resources of the school and appropriate school personnel to conduct such tests.

The most common test procedures include the following:

Cover test – A test of binocular coordination involving watching eye movements when each eye is alternately covered and uncovered.

Maddox rod test – a clinical test in which a special lens before one eye distupts fusion and gives a line image of a spot of light viewed with the other eye. The separation of line and dot indicates the amount of heterophoria.

Massachusetts Vision Kit (MVK) – a battery of tests, including a visual acuity test, plus sphere test, and Maddox rod test at distance and near.

Atlantic City Vision Test – a battery of tests including a visual acuity test, connex lens test, and a test for vertical and horizontal muscle imbalance.

Titmus School Vision Tester – a stereoscopic instrument for testing visual acuity at distance, heterophoria at distance and near, and a plus sphere test.

Ortho-Rater – a stereoscopic instrument for testing visual acuity at distance and near, heterophoria at distance and near, stereopsis (three-dimensional vision), and color vision.

Plus sphere test – a test to detect significant hyperopia (far-sightedness) by viewing a chart through a lens (+1.50 to +2.50 diopter spheres). If the chart can be read, the eye is hyperopic.

Sight Screener – a stereoscopic instrument for testing visual acuity at distance and near, heterophoria at distance and near, stereopsis, and color vision.

Snellen test – a test of central visual acuity using symbols of graded size viewed at 20 feet.

Telebinocular – a stereoscopic instrument for testing visual acuity at distance and near, heterophoria at distance and near, fusion, stereopsis, and color vision.

Worth 4-dot test – a clinical test for fusion.

Follow-up

Nothing has been accomplished for the referred child if parents fail to take him for examination. Where effective measures introduce the school eye health program, a better response will be obtained from the parents when examination of the eyes is advised. When the school fails to receive a report that the examination has been done, follow-up by the nurse is advisable. The school nurse is particularly qualified by training and public acceptance to acquaint the parents with the need and with their responsibility.

SCREENING FOR HEARING[1]

The Problem of the Hearing Impaired in New Jersey

"The problem of the hearing impaired in New Jersey has been a persistent one and of great concern to educators and parents of these children.

The 1964 report made by the Commission on the Handicapped pointed out that the educational needs of the children with hearing impairment were not adequately met.

At that time there were two large schools providing education for deaf children, one residential in West Trenton and the other a day school in Newark, New Jersey. A number of classes were operated by the school districts of Paterson, Jersey City, Elizabeth and Camden. The report affirmed that there was an enrollment of 800 children with severe hearing loss who required self-contained classes. However, at that time the results of the rubella epidemic in New Jersey in 1962-64 had not been felt.

Programs for children with less severe losses were negligible. The 1963 report on services for the handicapped showed that 181 children classified as hard of hearing were receiving special supplemental instruction in the public schools. The same report stated that there were additional children with moderate losses who could substantially benefit by special education services.

Since 1964, as a result of the increasing information being received regarding the epidemic, there has been some growth in programs for children with hearing impairment. More districts have started single class units and other districts have expanded their program. As of November 1, 1968, the total number of children being serviced in various public school and state operated programs for deaf and hard of hearing was 1,014.

Very recently several areas have joined to provide countywide comprehensive services for children with hearing impairment. Examples of these facilities and programs are those established in Hackensack involving school districts in Bergen County, and the center in the Millburn Avenue School, which receives children from districts in three counties. A third center is located in Corbin City and provides services to children with hearing impairment from Atlantic and Cape May counties.

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[1] *A Survey of New Jersey Children (Ages 2-6) who have Sensory Disorders involving Hearing Impairment,* New Jersey Department of Education, Trenton, New Jersey. Report to Governor Richard J. Hughes, November 1968. pp. 9-10.

Pre-school programs sponsored by private groups, colleges and speech and hearing clinics have been organized during the past year in some parts of the State. Notable among these are the Speech School in Summit, sponsored by the Junior League, the program at Newark State College and Douglass College, and several in speech and hearing clinics.

The Beadleston legislation, N.J.S. 18A:46 made provision for local boards of education to send handicapped children to public and non-public facilities in adjoining states. A number of hearing impaired children are presently enrolled in schools for hearing impaired outside the State of New Jersey. For instance, a number of children are at the Martin School in Philadelphia and a few attend the Lexington School for the Deaf in New York.

While this expansion of services has met the needs of some children, major problems still remain. These include early identification and screening of children with hearing impairment; development of pre-school services; on-going case-finding and census; and coordinated statewide programs. Special attention must be given to the multiple handicapped in both residential and day facilities; supplemental instruction to less severely involved handicapped children; teacher preparation; coordination of state departments; vocational education and adult education."

Definitions & Classifications

The following definitions and classifications of hearing impairment are taken from a Comprehensive Plan for Hearing Impaired Children in Illinois. This report was prepared by a Special Committee on the Hearing Impaired.

MEANING OF HEARING IMPAIRMENT

"Listening and talking are so much a part of everyday life that most of us take them for granted. It is difficult to conceive of a world in which some or all sounds are blotted out or distorted.

"The most serious effects of a hearing disorder are that communication between persons is interfered with and that the individual's sensitivity to his environment is distorted. Among children, hearing impairment may have especially far-reaching consequences:

"1. The most serious effect is its inteference with the normal development of language which is the vehicle of all human thought and learning. This effect pervades all the language functions of the hearing impaired child with the obvious lack of speech or distorted speech being only the most apparent manifestation.

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"2. It may interfere with a child's normal processes of speech development. Children who cannot hear cannot learn to talk without special help. Children who hear some sounds but not others often develop such distorted speech that it is almost unintelligible.

"3. A child born with severely impaired hearing or the victim of early hearing loss is deprived of much of the close give-and-take with his family and his surroundings which serves as a basis not only for speech and language but for social growth and behavior and personal satisfaction.

"4. If untreated, hearing impairment may interfere with education, especially through the child's failure to comprehend and use language. Children with uncorrected hearing loss may be thought to be mentally retarded, particularly when they fall far behind their classmates in school.

"5. Children handicapped by hearing loss may have serious problems of adjustment. With inadequate management, some may be over-aggressive, defiant or disobedient; others become withdrawn and may avoid competitive situations or shun group activities with classmates, thus forfeiting opportunities for stimulation and participation.

"6. Parents may have difficulty in adjusting to their child's handicap and the increased responsibilities it imposes. Lack of knowledge about hearing impairment, anxiety about their role as parents, feelings of blame or shame about the handicap may seriously disturb family relationships.

"7. The financial burden of providing special diagnosis, treatment, and training may fall hard on families and communities alike. The cost of education for deaf and hard-of-hearing children is three to six times greater per child per year than for children in regular school programs.

"8. The child's future as a contributing member of his community may be at stake — expecially as concerns his vocation and his ability to relate to and communicate with his neighbors."[1]

There are three principal types of hearing impairment which may co-exist:

1. CONDUCTIVE IMPAIRMENT is the term applied to a loss of

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[1] A Guide For Public Health Personnel-Services for Children with Hearing Impairment — prepared by the Committee on Child Health of the American Public Health Association, 1956, p. 11.

hearing resulting from any dysfunction of the outer or middle ear. The primary effect is a LOSS OF LOUDNESS. Perception of sounds is restored when the loudness of sounds is increased. Loss resulting from lesions of the outer or middle ear may vary from mild to moderate and rarely exceed 60dB (ASA) or 70 dB (ISO) through the speech-frequency range. These lesions are often preventable and a considerable number respond well to medical treatment including surgery when discovered early. Since the neural mechanism of the ear is unaffected, the use of a hearing aid is generally very satisfactory.

2. SENSORI-NEURAL IMPAIRMENT (NERVE OR PERCEPTIVE IMPAIRMENT) is the term applied to a loss of hearing resulting from dysfunction of the inner ear or the nerve pathway from the inner ear to the brain stem. The primary effect is a loss of TONAL CLARITY as well as a loss of loudness of sound. It is usually the perception of higher tones which is most affected, but when the loss is severe both high and low tones are involved. When the speech frequencies are affected, the clarity of words is distorted and intelligibility as well as awareness to sound is impaired. Since the sensory and neural mechanisms are involved, the benefits of a hearing aid may be limited. That is, the experience when using an aid may be one of increased loudness but limited clarity. Sensori-neural losses may vary from mild to total. Medical treatment can as yet do little or nothing for this type of impairment once it has become established. Prevention and early education are therefore of prime importance.

3. CENTRAL IMPAIRMENT (CENTRAL DEAFNESS) is the term applied to auditory impairments resulting from dysfunction along the pathways (tracts and nuclei) of the brain from the brain stem to and including the cerebral cortex. Although relatively little factual information is known concerning this disorder, the primary effect appears to be interference with the ability to perceive and interpret sound, particularly speech. Loss of loudness is not generally significant and consequently the decibel notation is inadequate for describing this type of impairment. Thus, central deafness is not a hearing-loss problem in the sense of the previous two definitions. It is a neurological disorder for which medical treatment can do little or nothing, therefore, the value of early education cannot be over emphasized. Loudness is not a primary factor. The value of a hearing aid in this type of hearing impairment remains controversial.

There are five general classifications of hearing impairment.

1. SLIGHT IMPAIRMENT results in difficulty in hearing speech under less than ideal acoustic conditions. A child with a slight hearing loss will not be able to hear faint or distant speech clearly, will probably

get along in school situations, and probably will not have defective speech because of the hearing loss.

2. MILD IMPAIRMENT results in some trouble understanding conversational speech at a distance of more than five feet. A child with mild loss will probably miss as much as 50% of class discussion if voices are faint or if the face is not visible. He may have defective speech if loss is of high frequency type and may have limited vocabulary.

3. MARKED IMPAIRMENT results in trouble hearing speech under most conditions. Conversational speech must be loud to be understood. A child will have considerable difficulty in following classroom discussion, may exhibit deviations of articulation and voice, may misunderstand directions at times, may have limited language, and his vocabulary and usage may be affected.

4. SEVERE IMPAIRMENT results in inability to hear speech unless amplified in some manner. A child with severe impairment may hear a loud voice at one foot from the ear and moderate voice several inches from ear. He will be able to hear loud noises such as sirens and airplanes. His speech and language will not be learned normally without early amplification. He may be able to distinguish vowels but not all consonants even at close range.

5. EXTREME (PROFOUND) IMPAIRMENT results in inability to hear and appreciate speech by ear alone even with amplification of sound. Deafness is a profound impairment in both ears which precludes any useful hearing. A child may hear a loud shout one inch from his ear, or nothing at all. He may or may not be aware of loud noises and his speech and language do not develop normally.

There are numerous variables which affect the identification, diagnosis and management. Often there is a combination of the following variables which must be considered:

age at onset of hearing loss – whether at birth or after the development of a normal language pattern;

degree of hearing loss – the amount of nature of useful residual hearing;

type of impairment – conductive, sensori-neural, or central damage; plus the physical condition, emotional stability, entelligence, motivation, and personality of the child;

timing of the treatment and management and methods followed;

family attitudes and quality of the home, school and community environments;

quality of professional and parental teamwork.

Hearing impairment is not an entity – it is a functional disorder. As such, it affects the total person and not just his hearing. Once the identity of an individual with an impairment has been ascertained, he may require otologic, audiological, psychological, educational and other scrutiny so that a comprehensive description of his total problem may be derived, a diagnosis made, and a sequence of management prescribed.

Recommendations for Screening

Although observations made by parents and teachers will identify many cases of ear disease and disorder they will not uncover all cases of impaired hearing. Moderate hearing impairment in both ears and severe impairment in one ear may exist without the child, parents or teacher suspecting that a problem exists. For this reason, the school has a primary obligation to establish a sound screening program.

The following hearing screening program is reprinted with permission. It is chosen for inclusion in this publication because the directions contained in the program are consistent with recognized recommendations for effective hearing screening in schools.

HEARING SCREENING PROGRAM: STATE OF NEW JERSEY, COUNTY OF MERCER

Aris M. Sophocles, MD
Robert Muzzarelli, MA

INTRODUCTION

PURPOSE: The goal of the hearing screening program is to locate children with hearing impairments through a formal and standardized approach. Detection of hearing impairments is essential for the total social and academic development of a child.

IMPLICATION: An effective hearing screening program affords the following:

1. *Preventive:* In many cases, the early discovery of a hearing loss can, through proper medical and/or surgical intervention, improve hearing or prevent further deterioration of hearing.

2. *Educational:* The discovery of a hearing loss can assist those individuals concerned with the child's academic potentials. Through early detection, a preferential seating or special academic

considerations can be offered that will allow the child to develop to his capabilities.

3. *Social:* Proper management of a child found to have a loss of hearing can prevent or, at best, assist in erradicating abnormal behavior, social unresponsiveness, or family discord which is known to occur as a result of a hearing loss.

In general, we are concerned with human potential. Since hearing losses can have an adverse effect upon human development, the formal hearing screening program must be incorporated in the total academic, conservation, social, and rehabilitative processes afforded our school age population.

SCOPE: Each child of school age shall be given, by methods herein described, a hearing test by a school nurse or "technician." For a more detailed statement regarding the training, qualifications, etc. of a "technician," please refer to Appendix.

STATEMENT: THE POLICIES AND PROCEDURES HEREIN OUTLINED SHALL BE CONSIDERED *MANDATORY.* ALL ASPECTS OF THE HEARING SCREENING PROGRAM SHALL BE FOLLOWED ACCORDING TO THE ATTACHED OUTLINE.

Procedure

A. GENERAL

1. *INITIAL SCREENING* of the following grades is *required:*

a- K, 1, 2, 3, 4, 5, 7, 9, 11, Special, ungraded classes

b- Referrals (teachers, special services dept., etc.)

c- New pupils entering the school

d- Pupils returning to school after a severe illness, i.e. meningitis, encephalitis

e- Pupils known to have had a hearing loss

2. *SECOND SCREENING* is to be done on all pupils who failed the initial screening. The second screening should be done no later than two weeks following the initial screening.

3. *TRESHOLD SCREENING* is to be done on ALL children who failed the SECOND screening test.

See appendix for rationale of General Procedures above.

B. SPECIFIC

1. Initial screening shall be performed on all pupils as described above.

2. The following frequencies and order of presentation are to be screened: 1000, 2000, 4000, 8000, 1000, 500, and 250 Hz.

Note: refer to Appendix for specific details.

3. Screening level: 25 dB ISO Standard (refer to Appendix)

4. Failure of the initial screening test is when the child has failed to hear *two or more tones at 25 dB in one or both ears.*

5. Failures are to be noted and RE-SCREENED (Second Screening) within two weeks. Technique and failure criteria used in the initial screening shall apply for the second screening.

6. Children who again fail are to be given the Threshold Test.

7. The Pure Tone Threshold Test shall be given within ONE MONTH of failing the second screening test.

8. Pure Tone Threshold Test: to be administered as directed in Appendix.

9. A child whose Threshold test shows a *hearing level of 25 dB or more for two or more tones in one or both ears OR 30 dB or more for one tone in either ear* SHALL BE REFERRED FOR A COMPLETE EAR EXAMINATION.

10. A complete ear examination means:
   - a- Otologic Examination
   - b- Audiometric Tests

11. Parents are to be informed of the child's failure of the Pure Tone Threshold Test IMMEDIATELY on the attached form.

12. Follow-up is essential! If, after one month, there is no report from the physician, contact the family by phone in order to ascertain what action they have taken.

13. In cases where specific recommendations are made, the nurse should inform all individuals involved with the child (e.g. teacher, principal, etc.)

Appendix

A. GENERAL PROCEDURES

Rationale: Studies have demonstrated that approximately 15% of the school population originally screened will fail the first hearing screening test. Of this 15%, approximately 1/3 or less will be found to have a hearing loss. By performing a second screening test on those children who failed the original screening, we can hope to diminish the number of children required to receive the Pure Tone Threshold Test. The purpose of the second screening then, is to eliminate the time consuming as well as costly Pure Tone Test on children who have no hearing loss. (For example, many children may fail the initial screening because of distractability, fatigue, noise, inattentiveness, etc. but pass a second screening because the original factor (s) causing the failure has dissipated.)

Failure to pass the initial screening but passing the second screening does not necessarily imply normal hearing but could possibly indicate susceptibility to temporary threshold shifts. Any child who consistently fails the first test but passes the second screening should be studied at other times during the school year.

B. SPECIFIC PROCEDURES

(1-4) Initial Screening:

a- The tester

(1) *School Nurse:* All testing should be done by the school nurse who has had proper guidance and education in the field of hearing conservation and screening. The school nurse is responsible for recording all failures on the child's school records, notifying parents, and supervising technicians.

(2) *Technician:* In cases where the responsibilities of the school nurse are such as to make the hearing screening program impossible (e.g.: too many students and schools under her jurisdiction to carry-out all phases of the program is the time limit stipulation), the use of technicians is permitted. Technician shall include speech and hearing therapists trained in audiometry and who are available for providing their services OR, any individual who has completed one course in Hearing Conservation or Introduction to Audiology at any institution of higher learning and who has satisfactorily demonstrated an ability to perform hearing screening tests. In cases where course titles differ from the aforementioned, a course description must be submitted from the college or university. The course content must include a study of types of hearing problems and a study of audiometric screening techniques and how they are administered. NO individual shall be permitted to act as "technician" unless the aforementioned qualifications have been met.

b- The Audiometer

(1) Audiometers are to be supplied by the local school authorities.

(2) The audiometer should be equipped to test the frequency range from 250 through 8000 Hz and should have at least one set of double head phones. Masking and bone conduction accessories are not required.

(3) All audiometers must be calibrated to the ISO-1964 Standards.

(4) Audiometers should be checked for calibration before each series of tests. This can be done quite easily by checking the pure tone thresholds on five normal hearing individuals. It is especially important that this be done if the earphones or audiometer have been dropped.

(5) Factory calibration is required once every two years.

c- *The testing room*

(1) Select a room for its quietness. If there is any doubt as to the effect of noises in the testing room (i.e. if it is too noisy), the following procedure is recommended: (a) Place both earphones over your ears; (b) Set the Hearing Level dial at 25 dB; (c) Sweep through the frequencies of 250, 500, 1000, 2000, 4000, and 8000 Hz. in one ear. The room is too noisy if you cannot hear any one of these frequencies. (NOTE: If you are aware that you have a hearing loss, you should test another normal hearing adult in order to determine if the room is suitable for testing).

(2) In advance of testing, arrange with the school administrator to have as little noise-producing activity as possible in the testing area.

d- *The hearing test*

(1) Begin by instructing the children to "raise their hand" when a tone or "beep" is heard. The instructions of the hearing test can be given to the entire class. It is also suggested that you demonstrate the procedure. NOTE: It is not necessary to instruct the child to raise his right hand if he hears the tone in his right ear and to raise his left hand if he hears the tone in his left ear. This approach often leads to confusion since many children, in not being certain as to which ear he is hearing the tone may not raise his hand. YOU are aware of the ear to which the tone is being delivered and that is the important factor.

(2) Place the earphones on the child. Be certain that the headphone is over the external canal and such items as glasses, earrings, etc. are removed before testing.

(3) Begin testing in the right ear. Set the Hearing Level (or Hearing Loss) dial at 50 dB. Present the tone in a few short "beeps" (the "on-off" effect helps the child detect the tone). When the child responds, turn the Hearing Loss dial to 35 dB and present same tone as you did before. Now

turn the dial down to 25 dB and test the tone again. If the child responds, he has passed the test for this tone. If he does not respond, he has failed the test for this tone.

(4) Leave the Hearing Loss dial set at 25 dB for the rest of the test.

(5) Repeat the procedure with the dial at 25 dB for the following frequencies (in order of presentation): 2000, 4000, 8000, 1000, 500, 250.

(6) Switch to the left ear and repeat as in #5 above.

(7) *Failure of the initial screening test is when a child has failed to hear two or more tones at 25 dB in one or both ears.*

(8) A notation should be made of all children who failed the test.

(9) The children who failed the screening are to be rescreened within two weeks. The technique and failure criteria are the same as used in the initial screening and as outlined in items 3 through 7 above.

(10) Children who fail the second screening are to be given the Pure Tone Threshold Test within one month of failing the second screening.

(6-10)

e- The Pure Tone Threshold Test

(1) Begin as in Screening Test (items 1 through 3)

(2) After the 1000 Hz tone has been presented at 50 dB and the child has responded, turn the Hearing Loss dial down to 10 dB and present the tone. If the child does not respond, increase the Hearing Loss dial by 10 dB steps until the child again responds. At this point, decrease the Hearing Level dial 20 dB below the point where the child had responded and then present the tone. Increase the dial by 5 dB steps until the child responds. Repeat this until you are able to determine the point where the child is "just able" to detect the tone. This is his threshold for the particular tone and should be recorded on the Audiogram.

(3) Repeat this same procedure until all of the following tones have been tested: 250, 500, 1000, 2000, 4000 and 8000 Hz.

(4) Perform the same procedure for the left ear.

(5) A CHILD WHOSE THRESHOLD TEST SHOWS A HEARING LEVEL OF *25 dB OR MORE* FOR *TWO OR MORE TONES IN ONE OR BOTH EARS OR 30 dB* OR MORE FOR *ONE TONE* IN *EITHER EAR* SHALL BE REFERRED FOR A COMPLETE EAR EXAMINATION.

(11) Referral Procedure

a- The parents of the children who fail the Pure Tone Treshold Test are to be informed of this fact. The "Report to Parents and Physician" form shall be completed and mailed to the parents.

b- The family is now responsible for arranging for a complete ear examination by a physician. This examination should also include Audiometric tests.

c- The family is requested to have the bottom portion of the form completed and signed by the examining physician. The form is to be returned to the school nurse immediately upon its completion by the physician.

d- If the physician requests an Audiologic Evaluation, the school nurse may assist the family in arranging such an evaluation at an appropriate audiological facility.

e- If the form has not been returned to the school nurse within one month, the nurse shall call the parents to inquire what course of action they have taken. If the family has not made any effort to have the child seen by a physician, the nurse shall make every effort to encourage the family to do so.

(12-13) Follow-up:

a- See item c above.

b- Upon receipt of the completed form, the nurse shall note any recommendations made by the physician. Such recommendations shall be noted in the child's school record.

c- If such recommendations as "preferential seating" are made, the nurse shall inform the child's teacher so that she may be aware of special needs of the child. Similarly, the school prinicipal shall be informed of special recommendations.

d- In cases where special academic considerations are requested, the nurse shall notify the Special Services Dept. of these needs.

C. DEFINITIONS

Audiogram – The record of the results of the hearing test in which the level of loudness at which the person can "just hear" a tone is plotted. (Threshold)

Audiometer – An electronic instrument for measuring hearing acuity.

Frequency – The number of double vibrations (or cycles per second) of a tone which make up that particular tone.

Hertz (Hz) – The term now being used for the unit of measurement of sound energy. Synonomous with cycles per second (Cps).

Masking – The term used when there is a large difference in hearing acuity between ears and requires that a noise be generated in the non-test ear to prevent that ear from perceiving the tone being presented to the worse ear.

Myringotomy – The surgical procedure in which an incision of the typanic membrane (eardrum) is made in order to allow fluid in the middle ear to be removed.

Preferential seating – A phrase used to indicate special seating for an individual with a known hearing loss. (e.g. Having someone sit on the right side of the classroom so that his ear which has substantially better hearing (left) can favor the classroom & teacher.)

Pure Tone – A sound of a specific frequency produced by an audiometer.

DeciBel (dB) – A unit of measurement of sound intensity.

Serous Otitis Media – A middle ear pathology in which an excessive amount of fluid has accumulated behind the eardrum and encompassed in the middle ear cavity.

Threshold – The lowest dB level at which a person responds to a tone at least 50% of the time.

D. FORMS

See pages 50, 51, 52, 53

REPORT TO PARENTS AND PHYSICIAN

Date:____________________ School ________________________________

To the parents of ________________________________, grade ________

A recent hearing screening test on your child showed the need for a more detailed examination. In the interest of your child, it is recommended that you consult your family physician for a complete ear examination.

Please have the doctor complete the form below and return to the school nurse.

Thank you,

School Nurse

- -

NAME:________________________________ DATE: ____________

A. Examination:

1. Pathology of hearing mechanism (describe):

Ear Canal________________________________

Tympanic Membranes________________________________

Presence or absence of wax, discharge, or other pathology____________

____

2. Cause(s) of condition ________________________________

____

3. Type of hearing problem:

None_____ Conductive_____ Sensori-neural (nerve) _____ Mixed _______

4. Stability of hearing condition:

Stable___ Progressive___ Improving___ Recurrent___ Permanent ______

B. Recommendations and Prognosis:

1. Medical and/or surgical treatment ________________________________

____

2. Prognosis________________________________

3. Educational recommendations (special seating, further diagnostic hearing tests, hearing aid, limitations in school activities, etc.)

____

____

____
(Physician's Signature)

PURE TONE THRESHOLD TEST

Name:________________________ Date _________ Tester ___________

School________________ Grade_____ Room _____Teacher ___________

ISO	250	500	1000	2000	4000	8000
10						
20						
30						
40						
50						
60						
70						
80						
90						
100						
110						

RELIABILITY

Good Fair Poor

Comments:

PASS_____ FAIL _____

Fail = 25 dB or more-two or more tones in one or both ears OR 30dB or more-one tone in either ear.

REPORT TO PARENTS AND PHYSICIAN FORM: sent to parents:__________ (date)

REPORT COMPLETED AND RECEIVED ON:_______ (date) PHYSICIAN_______ (name)

SPECIAL RECOMMENDATIONS TO SCHOOL (if any):______________

TEACHER NOTIFIED OF ABOVE RECOMMENDATIONS:____________ (date)

PRINCIPAL NOTIFIED OF ABOVE RECOMMENDATIONS:____________ (date)

OTHER COMMENTS (Such as "other type of contacts with parents, date, and what was discussed regarding the child's needs, etc.)

SCHOOL NURSE: __________________

INITIAL SWEEP SCREENING

DATE: ____________________

Grade____ School ______________ Teacher ______________ Room ______

Pupil's Name		250	500	1000	2000	4000	8000	Comments
	R							
	L							
	R							
	L							
	R							
	L							
	R							
	L							
	R							
	L							
	R							
	L							
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	R							
	L							
	R							
	L							
	R							
	L							

KEY: F = FAIL

Suggested procedure: Place an "F" in those frequencies not heard by the child. If child meets failure criteria as described below, place the word FAIL under the heading "Comments".

FAILURE: TWO OR MORE TONES IN ONE OR BOTH EARS.

ACTION: To be scheduled for re-screening within two weeks.

SECOND SWEEP SCREENING

DATE: ____________________

SCHOOL____________________

Name	Grade	Room	Teacher		250	500	1000	2000	4000	8000	Comments
				R							
				L							
				R							
				L							
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Tester's Signature:______________________________

KEY: F = Fail

Suggested procedure: Place an "F" in those frequencies not heard by the chold. If child meets failure criteria as described below, place the word FAIL under the heading "Comments".

FAILURE: TWO OR MORE TONES IN ONE OR BOTH EARS.

ACTION: To be scheduled for Pure Tone Threshold Test within one month.

SUGGESTIONS CONCERNING PUPILS WITH HEARING IMPAIRMENTS

Hearing and hearing loss, like all other faculties and problems, is highly individualistic and, therefore, requires that adjustments be made on an individual basis. The following are some general suggestions for adjustments which may be made in regular classrooms to and for the pupil with impaired hearing. Parents should be familiar with these suggestions and should discuss them with the child's teacher prior to the beginning of each school year and each time the child changes classroom teachers for any reason.

1. Remember that there are all degrees and several kinds of hearing loss. A child may have anything from a slight to a profound loss. He may have trouble hearing only high pitched sounds, or low pitched sounds. He may hear you but not be able to understand you. He may hear poorly at one time and almost normally at other times. Don't group all persons with hearing loss into one category. They are individuals and their hearing problems are individual. Take time with them. You may be pleasantly surprised and rewarded.

2. Any special consideration made for the hard-of-hearing pupil should be extended without calling attention to the defect. No child likes to feel that he must be singled out for special attention because he is different from the group.

3. If there is a difference in the hearing acuity of the child's ears, he should be seated so that: (1) his better ear is toward the group or toward the place where most of the conversation in the room will be held; (2) his back will be to the light; and (3) so he is able to turn and watch the teacher or any pupil who may speak without having to face the light himself. These arrangements will help him if he relies on lipreading and will also make his listening task easier.

4. The teacher should try to face the hear-of-hearing child as much as possible when speaking to the class. She should try to give important instructions from a position close to the child.

5. The child with a hearing loss should be continually and vigorously encouraged to listen to the teacher as well as watch her face for visual reinforcement when the teacher is talking to the class.

6. The hard-of-hearing child should be strongly encouraged to LISTEN to the children as they are participating in class activity as well as watch their faces and gestures.

7. If a choice of teachers is possible, the hard-of-hearing child

should be placed with the teacher who has good articulation, normal rate and volume.

The teacher should avoid the following:

(a) Moving around the room or covering part of her face with her hand or a book while speaking.

(b) Making explanations while writing on the blackboard with her back to the class.

(c) Standing too close to the pupil who must lipread. He might have to tilt his head back to see the speaker's face; an awkward position such as this will cause him unnecessary strain and fatigue.

(d) The use of loud tones, exaggerated lip movements, and forced facial expressions in speaking to a pupil with deficient hearing. Restating and rephrasing when the pupil fails to understand will be more effective than mere repetition.

8. A child who has a hearing loss lasting over a long period of time could develop a dull voice and inaccurate diction. Encourage the hard-of-hearing child to speak clearly. Refer him to the school speech therapist for speech conservation.

9. Interest in music should be encouraged, especially participation in vocal music.

10. Since a hearing loss is a defect which affects the language progress, the child should be encouraged to compensate by a more active interest in all language activities – reading, spelling, and so forth.

11. The hard-of-hearing child should be watched carefully to see that he is not withdrawing from the group or that he is not suffering a personal reaction as a direct result of his impairment.

12. The nurses and teachers should be especially vigilant in noting common colds, influenza, throat infections and so forth in this child. Such illnesses should be given medical attention as quickly as possible. The child should be referred for audiometric retests if there is any suspicion of fluctuating hearing thresholds. The child's ears should routinely be examined, at least once a year, both medically and audiologically. It is recommended that he use an ear, nose and throat specialist for such medical evaluation.

13. The hard-of-hearing pupil should be helped to become familiar with new vocabulary before a new topic is introduced to the class.

14. The pupil's apparent ability to hear may fluctuate. When he is closely attentive, he apparently hears quite well. The strain of watching

so intently in order to lipread is very great and the pupil tires quickly. It may be difficult to hold his attention if he is not periodically given time to relax and rest his eyes.

Reprinted from:
National Association of Hearing and Speech Agencies
919 18th Street, N.W., Washington, D.C. 20006

FOLLOW-UP OF SCREENING DEFECTS

The major goal of screening is to locate children with hearing impairments and to refer them to appropriate sources for medical care and treatment. Every child with a recurring or chronic hearing problem should be seen by an otologist.

Before referral is made any child who fails to hear two or more tones at 25 dB in one or both ears during the initial testing must be brought back for a retest within two weeks. Children who fail the second screening are to be given the Pure Tone Threshold Test within one month of failing the second screening.

Communication should be made to the parents as soon as possible urging an appointment with a physician and requesting a report. Parents may require assistance in following through particularly if no physician is available. The important point is that a decision be made as to whether the child may be properly treated by a physician or whether further referral to a hearing specialist is needed. If the physician's examination reveals normal hearing but the child continues to function as if a communication problem were present a further evaluation should be made.

In the event specific educational planning is necessary the school should have available all information concerning the findings of the otologist or hearing evaluation center.

The ideal referral is to a local otologist or an otological clinic However, at the present time these services may not be readily available. Parents need counseling and guidance in obtaining the best possible treatment and care for the child. The nurse can be of great assistance in informing parents of resources.

A directory of state and local hearing centers and specialized personnel is available from New Jersey Department of Education.

RECOMMENDED MINIMAL PROGRAM FOR HEALTH SURVEYS*

Grades	Ht.-Wt.	Vision	Dental	Phys. Exam.	Tuberculin	Audiometer
Pre-school and Kindergarten	X	X	X	X		X
1	X	X	X		X	X
2	X	X	X			X
3	X	X	X	X		X
4	X	X	X			X
5	X	X	X		X	X
6	X	X	X	X		
7	X	X	X			X
8	X	X	X			
9	X	X	X	X	X	X
10	X	X	X			
11	X	X	X	X		X
12	X	X	X		X	

Additional:

1. All new students.
2. Referrals.
3. Audiometric Testing following certain illness.
4. Audiometric Testing if speech deficiency is present.
5. Children with handicapping conditions--annual examinations.

*X indicates grades recommended for survey to be conducted.

HEALTH NEEDS IN SCHOOL ATHLETIC PROGRAMS

The administrative pattern of school health services varies considerably. Where there is a legally established school physician, the authority to make decisions on such matters as to whether a boy is medically fit to participate in athletics, or to return to participation following a disabling injury, rests with him. This should not be interpreted to mean that he usurps any of the functions of a family physician, or dentist, or that he does not cooperate in every way possible with other existing agencies or health services available to the family. It merely establishes where final authority in such matters resides.

The provision of an adequate medical examination, whether by school or family physician to insure physical fitness of all students to participate in any part of the physical education program, *but particularly in athletics*, is one of the most important health functions performed by the school. Such an examination, preferably given at the beginning of the school year, should identify individuals who are *not* physically fit to participate in certain phases of the program.

It should be emphasized that unnecessary exclusion of an athlete from participation might be just as undesirable educationally, or emotionally, as failure to exclude a boy who is physically unfit to participate might be from a medical standpoint.

The importance of having all injured athletes examined by physicians both at the time of their injury and prior to their return to competition, or even to physical education classes, cannot be overemphasized.

Today's physicians are becoming increasingly sympathetic with the coach's desire to return the athlete to competition at the earliest time compatible with health and safety.

One of the recurrent health problems in connection with School Athletic Programs is the practice of rigorous dieting or "drying out" in an attempt to make a lower weight for wrestling, or a light weight team sport. For an obese boy a reasonable reducing program under medical direction makes sense. In no instance, however, can a "drying out process" or a "crash reducing diet" be justified without adequate medical supervision and from a health stand-point *both practices are certainly questionable.*

The importance of proper conditioning and well-fitted protective equipment in safeguarding the health of high school athletes have both been so widely publicized ever since the original 1930 survey on *Safety In Athletics* by Lloyd, Deaver and Eastwood that one almost hesitates to mention what appears to be the obvious, yet a continuous turnover in coaches as well as an every-changing group of athletes required reiteration of these fundamentally important principles periodically.

The importance of close cooperation between the coach and school physician cannot be over emphasized. One means on insuring it is the development of written policies delineating responsibility for the care of athletic injuries. Such policies and procedures are particularly desirable in situations where athletic coaches are not trained physical educators.

One persistent complaint which is heard in some parts of the country is that a few physicians write blanket excuses from physical education for students without sufficient cause. If this does occur, it is infrequent and is probably due to lack of understanding of the nature of the physical education program.

A detailed discussion of the scope of medical problems in athletics, legal implications in athletics and athletic screening tests cannot be included here. It should be emphasized that every school should have a formal written code governing responsibility for athletic activities. A clear definition of the separate duties and responsibilities of each, physician, nurse and school administrator is basic to any program aimed at reducing accidents during sports participation.

PRE-SPORTS PHYSICAL EXAMINATION

The scope of the physical examination is usually decided upon by the physician. A physical examination for sports should include a meticulous medical history and physical examination which covers:

(1.) The external appraisal - orthopedic or surgical problems, and

(2.) The internal - the recognition of medical problems which may be a hazard to competition in competitive sports.

Cardiovascular disorders represent one of the most important of the latter. Careful evaluation is essential and since the cardiac examination is largely concerned with heart sounds, it should be performed not in the noisy atmosphere of the locker room but preferably in the quiet of the health room, team physician or family physicians office.

Heart murmur is common. Apical systolic murmurs may be found in a number of school age subjects but about one half of these are functional and not disqualifying. However, some abnormalities are difficult to differentiate from an innocent murmur and special study should be made to discover findings which would disqualify the young person from sports.

Blood pressure should be a routine part of the physical. An elevated blood pressure should be investigated to determine the cause and possible effects upon the body which would occur from competitive activity.

Urinalysis should be part of every examination of the athlete to screen for kidney disease or other conditions that might be further aggravated by contact sports.

Diabetes Mellitus is not necessarily a disqualifying condition in the athlete, if it is properly controlled. However, diabetics should be informed that strenuous exercise results in the production of more endogenous insulin and it may be necessary to take extra carbohydrates during sport activities.

Excellent resource material on school athletic programs — the elements of a good preventive program, conditioning exercises, protective gear, etc., is available for those interested in securing more data and direction.[1] [2] [3]

The American Medical Association has a guide for organizing a high school injury conference[4] which would be a great help to communities interested in sponsoring such an affair. It particularly stresses prevention of accidents by having the team physician responsible for determining a player's fitness for sport participation and by his being available at contests to provide immediate care in case of injury.

Another series of panphlets recommended for the coach are entitled, "Tips on Athletic Training I, II and III."[5] They contain invaluable ideas in regard to safeguarding the health of athletes on such matters as the use of antibiotics, pep pills and vitamins, food fads and facts, how to move an injured person, if necessary, the common drinking cup, hot weather hints (particularly the danger of heat stroke or heat exhaustion) and immunizations for athletes.

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[1] Ryan, A. J. Medical Care of the Athlete, New York, McGraw Hill, 1962.

[2] O'Donaghus, Treatment of Injuries to Athletes, Philadelphia: W. B. Saunders Company, 1963.

[3] Taylor and Novich; Training and Conditioning of Athletes, Philadelphia, Lea and Febiger, 1969.

[4] Protecting the Health of the High School Athlete, a Guide for Organizing a High School Sports Injury Conference, Committee on Injury in Sports, Chicago, Illinois, American Medical Association.

[5] Tips on Athletic Training, I, II, III. Comments by the National Federation of State Athletic Association in cooperation with the American Association, Chicago, Illinois, American Medical Association, 1960.

CUMULATIVE HEALTH RECORDS

What type of health record is best?

No one type of record is feasible for all situations. Comprehensive records may include a number of forms such as the pupil's medical record, teacher's health observation card, the accident record and other administrative forms.

Health records should be developed to fit the school district in which it is to be used. The development of a particular form should be a cooperative project of those who will make use of it. This is particularly true in regional school districts where the child transfers to different schools as he progresses. Information is much more likely to be uniform and accurate if the same forms are used throughout the district and are transferred with the pupil through senior high school.

Some schools have found that the use of a Color Tab System to designate children who have defects or handicaps has great value. Certain colors signify a particular condition and serve as a reminder for follow-up action as long as the handicap exists. This method also allows rapid calculation of the number of handicaps in various categories.

Children for Whom Health Records Should be Kept:

A health record card is to be made out for each pupil at the time he enters school and should be kept current during the child's progress through school.

Health data obtained from preschool health supervision should be transferred to the permanent school health record.

Information to be Included in the School Health Records:

1. History of diseases, accidental injuries and operations.
2. Immunizations and communicable disease testing (TB).
3. Physical examination findings and recommendations for follow-up.
4. Screening tests (vision, hearing, etc.).
5. Recommendations of professional people who serve the child.
6. Observation by the teacher of health behavior and appearance.
7. All available data bearing on the growth and development of the child.

How They are Used:

1. School health records are *confidential.*

2. They should be made available to selected school personnel whose responsibilities are such that access to health records is necessary for more effective individual educational planning.

3. Health information should be imparted to other agencies or individuals only on request of the parents and at the discretion of the school administrator.

4. Information which is not appropriate to be included on the cumulative health record may be recorded and kept in a confidential file which is accessible only to designated personnel.

5. Teachers should obtain health data information by requests through appropriate administration channels. This is recommended because of the confidential nature of the record and because medical data is often misunderstood by non-medical personnel. Interpretation by a qualified person results in better understanding and use of the information.

6. The administration should be encouraged to employ clerical staff whenever possible in order to reduce time spent by the physician and nurse in clerical duties.

VALUE OF HEALTH RECORDS

As they pertain to individual health:

1. Provides systematic history of health status through school years.

2. Provides data which concerns all aspects of health – physical, social and emotional. The integration of information which has been gathered by the teacher, counselor, psychologist, social worker, etc., will give a more accurate picture of a pupil and his health problem.

3. A record of health status can be of considerable value in guiding the child into the vocation for which he is most suited.

4. Health records should show the progress the child is making in attaining maximum health within the limits of his potentialities. The data should also reveal areas where more emphasis should be placed for positive health habits.

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As they pertain to group health:

1. Group data reveals trends in health behavior and practices. Disease incidence, accident frequency, nutritional needs, etc. Such data help to disclose major health problems.

2. Provides information to be used with parents, teachers, students and others for enlisting cooperation in combating a major health problem.

3. Data may be useful in planning curriculum in health education in order to place emphasis upon areas of greatest need.

4. Health records furnish information that is useful in evaluating the results of the school health program and in planning for future needs.

PART III

OTHER PROGRAMS

COMMUNICABLE DISEASE CONTROL

The Purpose of the Control and Prevention of Communicable Disease

Much progress has been made for effective control of communicable disease, however the school continues to have a responsibility to establish policies and procedures which will:

a. Prevent communicable disease through immunization.

b. Prevent further spread of communicable disease by encouraging prophylactic use of drugs and antibiotics.

c. Aid in the control of communicable disease (by isolating the ill child until he is taken home).

d. Discover unknown cases of communicable disease (by testing, x-ray, etc.).

e. Encourage pupils to safeguard their health and the health of others.

Education Relating to Communicable Diseases

Parents, teachers and pupils need to understand their roles in communicable disease control. Their effective participation in control measures depends on knowing what to do and how to do it.

a. Communicable disease instruction should be cooperatively planned by principal, teacher, physician and nurse. Teaching materials should be prepared for specific grade levels.

b. *Teachers* should be informed as to *signs* and *symptoms* which might indicate early signs of a communicable disease, and *course* of *action* to be taken.

c. The *pupils* should be taught to develop responsibility for their role in prevention and control:

1. To remain at home when ill.
2. To report to the teacher when they become ill at school.

3. To avoid contacts with others who have colds or other communicable diseases.

4. To understand and respect rules and regulations concerning measures for control — isolation period and incubation period, etc.

5. To follow immunization schedule as recommended by the Department of Health.

d. *Parents* must become informed about school regulations and policies. Their cooperation should be sought by requesting them to observe each child daily in order to help prevent exposing a group to a child who might be in the first stage of a communicable disease.

School Nurse Responsibilities are to:

Interpret rules and regulations to teachers, parents and pupils.

Help them to develop skill in detecting early signs of sickness in order to isolate any child showing symptoms of illness.

Acquaint them with recommended immunization procedures.

Urge that the services of the school nurse be utilized for advice and assistance in helping pupils gain an understanding of communicable disease.

Plan with the principal and school physician the procedures for exclusion and readmission, care of contacts and immunization policies.

Report immediately to the local health department or State Department of Health any unusual incidence of illness which might indicate need for control measures (such as unusually high occurrence of flu, hepatitis, etc.).

Record all data regarding communicable disease and immunizations on pupil cumulative health record.

Inform parent of communicable disease contact in classroom when advisable.

Follow up suspected cases of communicable disease.

Discuss with parent convalescent and home nursing care.

Explain the readmission procedures to parents.

Explain the importance of a thorough physical examination following severe illness. A statement may be needed from the doctor as to physical education participation.

Comments on Specific Communicable Diseases

A few diseases deserve special mention because of recent methods of control through the development of antibiotics and drugs and because of their particular significance in school situations.

Ringworm, pediculosis, scabies and *impetigo* are communicable conditions that are spread through contact and may occur in a comparatively large number of children. These children should be excluded from school while they are communicable. Early detection and appropriate medical treatment usually renders the condition non-communicable and they may return to school.

Impetigo and *staph infections* are one and the same thing. These need to be treated. The student should not be in school if untreated, or if ill from the lesion. Cleanliness should be stressed. Children with this condition should not be permitted to participate in contact sports until fully recovered.

Students with infectious *mononucleosis* should be excluded only during the acute illness when they are too ill to be in school. They should return to school with specific instructions from the physician as to limitations of activity. A full schedule of study and athletic participation should be resumed only upon order of the physician.

Recommended Immunization

Many schools are presently reviewing and revising their immunization requirements. These are the current recommendations for active immunization and for booster doses of vaccines. Recent studies indicate that booster doses particularly tetanus are being given too often in some areas.

After entering school, most children will not need boosters for tetanus, diphtheria and smallpox until about tenth grade.

Ideally, the first series of three injections against diphtheria, whooping cough and tetanus should be given early in the first year of life. A fourth dose should be given in the second year of life, and a booster dose at about the time of starting school. Thereafter, every ten years a booster dose of adult-type tetanus-diphtheria toxoid should be given. Additional doses of tetanus toxoid may be needed at the time of severe, tetanus-prone injuries. It is *not* considered necessary to give tetanus boosters to members of football and other athletic squads more frequently.

Smallpox vaccination should be performed initially between ages 12 and 24 months. A second vaccination should be given at the time of school entry. Subsequent boosters are probably needed only at ten-year intervals, although some authorities recommend that they be given somewhat more frequently. Also, booster doses are required within three years before returning from travel abroad.

After initial immunization against measles and mumps no booster doses are currently suggested. All children should receive a booster dose of trivalent oral polio vaccine at the time of starting school, but no subsequent doses are needed.

Tuberculosis

Tuberculosis continues to be a threat to the population. Tuberculin Testing Programs in the schools are the first line of defense.

The State Board of Education requires that all pupils of grades 1, 5, 9 and 12; all special students enrolled in the high school whether as undergraduate or as post-graduate; new pupil admissions from a school district who come without a record of a previous test for tuberculosis, shall be tested or examined as early as possible in each school year to determine the presence or absence of active or communicable tuberculosis.

Any board of education may require the pupils in other grades be examined if in its opinion there is reason to suspect the presence of active or communicable tuberculosis.

The Tuberculosis Council of New Jersey has made provision for a "School Tuberculin Testing Guide" to assist school administrators, physicians, teachers and nurses to conduct uniform and efficient screening programs, utilizing the tuberculin test as the initial screening tool.

The first *School Tuberculin Testing Guide* was prepared by a committee of the Tuberculosis Council of New Jersey in 1963-64, supplementing the then current rules and regulations for tuberculosis screening in the schools adopted by the State Board of Education on February 5, 1964.

On May 7, 1969, the State Board of Education adopted revisions to these rules and regulations submitted by an interdepartmental committee of the State Departments of Health and Education, based upon changes recommended by the Tuberculosis Council. Subsequently, the Council recommended that because of the revised rules and regulations, the *School Tuberculin Testing Guide* be updated.

The changes recommended by the Tuberculosis Council were based upon recent advances in the technology of tuberculin testing and prevention of disease.

This Guide is designed to provide the school nurse and the school physician with procedures that may be used in conducting a school tuberculin testing program. It is recognized that in some communities, the Board of Education must assume full responsibility for the program in public schools, while the Health Department may take the initiative for non-public schools.

The tuberculin skin test is an effective and essential tool in any tuberculosis control program. It is the preferred method of screening students and school personnel for tuberculosis, and has replaced the chest X-ray for large scale screening programs. The chest X-ray is to be used only when children and school personnel react to the tuberculin test, thereby reducing exposure to unnecessary radiation.

The Guide includes:

Current Statutes and State Board of Education Rules
Planning for Tuberculin Testing Programs
Procedures for the Administration and Reading of Tuberculin Tests
Notification, Records and Reports
Procedure for Follow-up of Tuberculin Reactors
Guidelines for Cooperation

Copies of this Guide may be obtained from:

The Office of the County Superintendent of Schools in each county.

The New Jersey Tuberculosis and Health Association.

The New Jersey State Department of Education, Office of Health, Safety and Physical Education.

The New Jersey State Department of Health, Division of Preventable Diseases.

Recommended resources for further information on tuberculosis:

DIAGNOSTIC STANDARDS AND CLASSIFICATION OF TUBERCULOSIS — 1969
National Tuberculosis and Respiratory Disease Association, 1740 Broadway, New York, New York 10019.

CLINICAL NOTES ON RESPIRATORY DISEASES, Vol. 8, No. 2
Fall 1969. American Thoracic Society, 1740 Broadway, New York, New York 10019.

SPECIAL EDUCATIONAL SERVICES

Provisions for exceptional or handicapped children involve application of school laws existing in the state. These laws include the method for classification of the types of handicapped or exceptional children; administration of the state services at the local level and types of education and care provided.

The purpose of this legislation is to urge an examination *in depth* of almost every child. For the best interest of the child this examination should be performed as early in the child's life as possible.

Basic to all programs is the classification of the suspected defect. Such classification should be made upon a basis of examinations to include:

1. Medical

a. Medical examination by a specialist to examine for the suspected handicap.

b. Medical examination in depth to determine multiple handicapping conditions.

2. Psychological

To determine intellectual functioning and personality assessment.

3. Educational

a. An assessment of educational needs to be made by an educational specialist.

b. Educational programming as recommended by the child study team.

Case-Findings

The school physician and nurse should, by reason of their experienced training in observing – symptoms, behavior, reactions to medication and illness, and physical characteristics – be singularly capable in the early detection of the type of the exceptional child, the slow learner, the retarded, the handicapped or the gifted. They should recognize their responsibility to make referral of such exceptional children to the proper medical and educational authorities.

Communications

Interdepartmental relationships should be carefully maintained. The administrator should be notified of all physical and emotional problems.

The administrator and teacher should also keep the physician and nurse informed of all those findings of which they become aware through parent contacts.

The physician and nurse can be of help in interpreting the educational implications of the findings to teacher and administrator as well as to parents. They can aid in the adoption of the program for the handicapped child.

Classification

The physician and nurse should see that the child has been examined for all physical and neurological findings before being referred for psychological evaluation.

It is the responsibility of the administrator to discuss classification of the students with the parent. All preschool registrations should be screened before the children are permanently registered. The school physician and nurse may help parents to understand the situation.

Emotionally and Socially Handicapped

When district child study teams have been organized under the 1959 Beadleston Act providing for special educational services for emotionally and socially maladjusted pupils, it is strongly recommended that the nurse be included as a team member because of her knowledge of the total health status of all pupils.

Follow-up

The school physician and nurse are in an excellent position to give guidance to parents of handicapped children. They have the professional contacts which will enable them to be consultants in terms of medical care and resources. By frequent home visits and contacts the nurse can facilitate the efforts of the medical profession and child study team by giving the family much needed comfort and help during a difficult period of adjustment.

Record Keeping

Clear, concise, confidential records must be kept on all handicapped children and dates should be included with all findings. If the child is transferred to a new school, records should be sent directly to the medical department of the new school upon request of the new district. This method avoids confidential matter from becoming general information. Records which are confidential in nature should be treated in such a manner that they are accessible only to the proper school authorities and every precaution should be taken to ensure their safekeeping and confidentiality.

Public Relations

The nurse as a liaison between home, school and community must, of a necessity, keep herself informed of community organizations which can offer aid to the school and parents for normal, handicapped and exceptional children.

Through her public contacts she should be able to help implement the understanding of the public for the value of special classes and especially programs for the handicapped.

The Parent-Teacher Organization is an excellent medium through which to help community understanding of all special programs.

The nurse does her utmost to keep school administrators informed as to recent advances and research in mental retardation.

Special Classes:

In schools where special classes exist, an excellent opportunity is afforded the nurse to work with the children in areas of health. This enables the nurse to provide opportunities to work with the teacher and students to develop programs which will help to develop a better understanding of sound health practices.

The Nurse as a Member of the Child Study Team

The nurse has a number of important contributions to make to the child study team. Due to the nature of her work the nurse is often the first person to become aware of an emotional problem in a child or of a home situation which may be affecting school performance.

The nurse's home visit is often one of the first steps taken informalized child study sequence. Since mental, emotional and physical health are highly interdependent the observations which are made regarding home environment and family interrelationships may be of primary importance in planning for a future course of action.

Her observations together with the physical health information and the teacher's bahavioral description may form the basic data for the child study team.

An informal discussion between the school nurse and the school psychologist regarding a potential case is desirable before writing up a formal report for the consideration of the team.

It is, of course, understood that the nurse will at all times confer with the school physician, the principal, and guidance counselor regarding any action on her part.

At later stages of case development, if the utilization of medical facilities seem desirable, the nurse and school physician may be helpful in interpreting this need to the parents, and in helping to facilitate the appropriate contacts.

HEALTH OF SCHOOL PERSONNEL

Physical Examination for Employees

The health of all personnel is important to the total school program. A good optimistic emotional climate is necessary to create the proper environment for effective learning. Sound physical and emotional health in all school personnel will help them to carry on their work efficiently and effectively. It also contributes to a happy normal life.

Procedures relating to periodic medical examinations for school personnel should be developed locally. Important principles which should be given consideration should include:

1. Pre-employment health examinations which are comprehensive enough to determine conditions that would:

   a. Impair the applicant's ability to teach.
   b. Constitute a public health hazard to students.
   c. Disclose a condition (physical, mental or emotional) which could make the job a hazard to the applicant.

2. Provisions for a continuing program to promote and maintain the health of school personnel. Factors to be considered should include:

   a. Specified intervals for physical examinations.
   b. Provisions for examinations at times other than periodic requirements, if, in the judgment of the appropriate school authority, such a measure seems necessary.
   c. Provision for examination following frequent or prolonged illnesses.
   d. Psychiatric interview or consultation if there appears to be a need. For an employee to consult a psychiatrist is as fitting as for him to see a heart specialist.
   e. Policies concerning financing the program. Are the examinations to be carried out by any licensed physician or by specified examiners?

f. Administrative understanding and support to the health needs of school personnel. These needs are emotional as well as physical. Good school conditions – classes that are not too large, teaching loads that are equalized, minimal classroom interruptions, classroom environmental conditions and many other factors influence teaching performance. Administrative procedures can do much to help meet the emotional needs of employees and to give boards of education greater insight into the importance of action for positive teacher health measures.

3. All school personnel – administrative, instructional and service – should be included in the program.

Confidentiality of Medical Records

The findings of the health examination must be kept confidential and placed in confidential files.

When using the suggested examination form, it is recommended that the physician keep the form with its detailed information in his files and return the employee's certification. This certificate shows only that the applicant or employee is free or not free of conditions which might affect his job ability. There is also space for the physician to recommend job limitations due to any defects. An authorization is provided so that health information can be released to the superintendent, if a health need arises.

Not only will periodic physical examinations help maintain sound physical and emotional health on the part of employees, but by precept the practice will become a good example for the students.

THE SCHOOL DENTAL HEALTH PROGRAM

All dental health programs should emphasize prevention and control of dental diseases through knowledge of their causes, use of approved preventive measures, and regular visits to the dentist followed by adequate care.

Because of the prevalence of dental caries in children and youth, it has been a common practice to give almost exclusive attention to this disease when school dental health programs are planned. The destructive effect of tooth decay should not be minimized, but there are other dental defects and conditions, such as malocclusion and periodontal diseases that should be given their share of attention in program planning.

SUGGESTED MEDICAL INFORMATION FORM
FOR SCHOOL EMPLOYEES AND APPLICANTS

1. Please answer all questions pertaining to medical history before visiting your family physician.
2. After the physical examination, request your physician to complete the certification form at the bottom and mail it directly to the superintendent of schools.

- - - - -

When did you last consult a physician and for what purpose? ______________________

____

What illnesses have you had within the past 5 years? ______________________

____

Name and address of family physician: ______________________

Hospital or sanitarium confinement:

Reason	Where	Year

Explain any vision or hearing difficulty ______________________

____

Date of last successful smallpox vaccination ______________________

Date of last immunization against diphtheria ________ tetanus ______ polio ______

	Yes	No
Have you lost or gained weight during the past year?		
Are you taking medicine regularly?		
Do you have a health complaint at the present time?		
Have you ever been refused insurance or "rated up" by an insurance company for health reasons?		
Were you discharged from the Armed Forces for medical reasons?		
Have you ever lived with or worked with anyone having active tuberculosis?		

Amplify any "Yes" answer:

I hereby certify that the above answers are true ______________________
Signature of applicant

______________________ ______________ __________
Address Telephone No. Date

SUGGESTED MEDICAL INFORMATION FORM FOR SCHOOL EMPLOYEES AND APPLICANTS

PHYSICIAN'S EXAMINATION

Name of Applicant or Employee ____________________

Height ________ Weight ________ Blood Pressure ________ Date of Birth ________

Vision (Snellen):

Corrected, R 20/______ L 20/____ Uncorrected, R 20/______ L 20/______

Hearing (pure-tone):

	Right Ear	Left Ear
Markedly impaired	________	________
Slightly impaired	________	________
Normal	________	________

General Appearance ____________________

Note any deviations from normal in examination and review of the following:

Eyes ____________________

Ears, nose, throat ____________________

____

Cardiorespiratory ____________________

Lymphoid system ____________________

Nervous system ____________________

Gastrointestinal ____________________

Musculoskeletal ____________________

Genitourinary (include menstrual history) ____________________

____

Skin, hair, nails ____________________

Other ____________________

____

____

Note any physical deformity ____________________

Date and result of most recent Mantoux test ____________________

If Mantoux test positive give result of chest x-ray ____________________

Where taken ____________________

Note any abnormalities of urinalysis ____________________

Hemoglobin ____________ Other ____________

Physical or mental condition materially affecting the efficiency of this individual's school employment:

Comments:

Date ____________________

____
Physician's signature

____
Address

- -

EMPLOYEE'S CERTIFICATION

(Return to the Superintendent of Schools)

Name of Applicant or Employee ____________________

Is the applicant free of any condition which might affect his ability to do his job?

____

If not, what limitations are advised? ____________________

Results of tuberculosis tests: Mantoux ______ positive ______ negative ______

Chest x-ray ____________________

Date ________________

____
Physician's signature

I authorize release of all information to the superintendent of schools, if the need arises.

____
Signature of applicant

Dental health is known to affect the general health, the appearance, and social adjustment of an individual throughout his lifetime. The control of dental disease and defects and the establishment of good oral hygiene habits are best accomplished during childhood.

The following objectives can guide the direction of the school dental health program toward achievement of its goals and help every child obtain and maintain his teeth in a healthy condition throughout life:

To help every school child appreciate the importance of a healthy mouth.

To help every school child appreciate the relationship of dental health to general health and appearance.

To encourage the observance of dental health practices, including personal care, professional care, proper diet, and oral habits.

To enlist the aid of all groups and agencies interested in the promotion of school health.

To correlate dental health activities with the total school health program.

To stimulate the development of resources for making dental care available to all children and youth.

To stimulate dentitsts to perform adequate health services for children.

The value of education can be determined by the way the pupil applies the knowledge gained to actual practice. Here the school can help by actually putting into practice its teachings, such as controlling the sale of cariogenic items within the school building during the school day, conducting toothbrushing in the lower grades, and promoting programs for the proper use of fluorides as caries inhibitors.

Dental surveys of school children by the local dentists provides data valuable in determining the dental needs and services rendered in a specific area. This may help guide the direction of the dental health program.

However, inspection of children's teeth by teachers or nurses is not recommended since these persons do not possess the training or equipment necessary to detect any but the most obvious defects.

Unless parents are sold on the dental health program, the school program will be largely ineffective. It is the parents who must take the children to the dentist and pay for necessary dental treatments.

One of the primary dental health functions of the school should be the distribution of authentic dental health information to adult groups particularly parents by means of literature, films, conferences and talks and by constantly urging parents to obtain adequate dental care for their children and to provide a good example for the children by obtaining such care for themselves.

Children's teeth should be maintained in good condition even before the children enter school. To assure this every community should build up a preschool dental health program which would include all children who have not entered school (newborn to 5 or 6 years.)

THE SCHOOL NUTRITION PROGRAM

There are two parts to the nutrition program: (1) classroom instruction in nutrition and (2) the school lunch, which is a health service as well as an educational experience. The instruction can help the child best utilize the school lunch service. The school lunch should be used as a visual aid for teaching nutrition.

The objectives of a nutrition program should include activities to help pupils:

To create a desire for good nutrition.
To establish wholesome attitudes toward foods.
To develop desirable eating habits.
To understand the relationship of good food habits to health.
To learn how good nutrition may be achieved through wise food selection.
To become familiar with nutrition problems of our society.

A good nutrition program is one based on the nutritional and development needs of the particular pupils being taught. To meet these needs the following factors must be considered: socio-economic levels of the families; cultural backgrounds represented; and the available food supply. Basic educational principles should be applied to nutrition education.

Nutrition education materials such as films, booklets, and current annotated bibliographies for primary, intermediate and secondary school teachers are available from the New Jersey Department of Health. The Department of Health also offers nutrition consultation to teachers, nurses, and administrators.

Those children with special nutrition problems require medical supervision. School personnel and public health nurses may be requested to help find practical ways of meeting the nutritional needs of such children in school. School lunch food service personnel should not assume responsibility for therapeutic diets.

School Lunch Program

State educational agencies are responsible for administering the program in the states and local districts assume direct management of the program. The two prime requisites under the National School Lunch Contract are that a lunch must be available to all children regardless of their ability to pay, and without discrimination, and that the lunch should meet the Type A lunch requirements.

The school should integrate the school lunch with the total education program to:

1. Promote good nutrition.
2. Promote good social habits.
3. Develop in children the habit of eating a variety of foods.
4. Demonstrate proper food handling to the school and community.

The school lunch can be a valuable learning laboratory with many classroom activities relating to lunch activities.

Children learn to enjoy the texture and taste of new foods through experimenting and helping to plan menus. They learn what constitutes a balanced diet and how the body needs and uses essential foods. Here is a perfect example of representation by students working on a health committee comprised of the school lunch supervisor, nurse, health teacher, or physical education teacher.

In districts where the School Lunch Supervisor is not a professionally trained dietitian, the school physician and the school nurse can make valuable contributions, including:

Work with parents, teachers, and children to improve the nutrition habits of children.

Encourage development of a school lunch program where the need exists.

Explain the lunch program, its aims and goals, to parents.

Work with principal to determine need for free lunches.

Inspect kitchen and dining area for standards of sanitation.

Help organize cooperative health and nutrition workshops and conferences.

Discourage the sale of beverages, candy or other confections in schools.

For rules concerning health regulations for school lunch personnel refer to:

"School Laws and State Board of Education Rules and Regulations for Health" 'Revised 1968'

PRESCHOOL HEALTH APPRAISAL

Screening for defects which might impair educational achievement is of major importance in the preschool child. Physical defects, abnormalities in development, emotional disturbances and diseases that have not yet shown outward signs may be discovered and treated. The sooner trouble is spotted, the easier it is for the physician, dentist and parents to do something about it.

For this reason, it is important for each elementary school to have a well-defined preschool health program whose objectives are:

1. To secure as much information as possible regarding past illness, accidents, operations, immunications, patterns of growth and development and known defects.

2. To encourage parents to take responsibility for preschool physical and dental examinations and to follow through on the physician's recommendations for correction of defects and for immunizations.

3. To urge parents to make particular efforts to have the child examined for vision and hearing. Most sight and hearing problems of childhood have their onset in the first years of life, are most susceptible to treatment then, and if undetected and not corrected, may become permanent defects.

An example of such condition is "Amblyopia Ex Anopsia", commonly referred to as the "lazy eye." This defect is of major concern to eye specialists because the condition is often unable to be detected without professional examination, and if not corrected, there is apt to be a serious loss of vision in the affected eye. A visual acuity examination given at three or four years of age may reveal the defect while it is still susceptible to treatment.

4. To aid parents in planning for medical care for correction of defects when necessary.

Arrangements for this can be made through the aid of the school or family physician and community resources.

5. To give the parents knowledge of the objectives of the school, to give them an understanding of the relationship between health and learning ability.

Preschool health appraisal may be accomplished through a variety of approaches.

1. Home visitation by the nurse to each child eligible to enter school in September.

This is an ideal way to facilitate the child's transition from home to school. However, there may be factors such as heavy nurse-pupil ration, responsibility for several schools and other administrative factors which would not allow time for visitations.

2. School visitation by parent and child.

Arrangements should be made for such an orientation visit early in spring. At this time parents would be given an opportunity to meet the principal, kindergarten teacher, school nurse, physician and dentist, if possible. The purpose of the visit would be to provide the child with a pleasant setting for his introduction to school and to acquaint the parent with the health requirements and objectives of the school health program.

Physical examinations are discouraged at this initial visit. A more profitable use of health and medical personnel is to talk with the children and parents to explain the importance of a complete physical examination prior to admission to school. Physical examination forms can be given to parents at this time with the request that they be filled in by the family physician and returned to school before a certain date.

A warm welcome, a visit to the kindergarten, tea and punch served by volunteers, such as PTA members, and an expression of sincere interest in the welfare of each child will do much to establish proper attitudes in both parent and child.

Follow-up

The preschool orientation has little value unless there are well established plans for follow-up and assurance that the child receives medical and dental examinations.

Every effort should be made to encourage parents to send in the completed health record forms by the date requested. Data can then be transferred to the child's cumulative health record form. Plans can be formulated for those children who may be in need of special attention or program.

HEALTH COUNSELING

The school nurse is in a unique position to gather data about children and to interpret it. Counseling is an integral part of her daily work, regardless of what particular phase of the health program she is currently involved. Parents can be helped to understand educational goals and children can be made to feel that their needs are understood if a good relationship can be established early in the school years. There is a new emphasis upon the utilization of personnel in health fields which means a more expanded and dynamic role for the nurse.

Goals of Health Counseling

1. As they relate to the individual:

a. To help pupils to understand their problems and to view them in a realistic manner. In other words, he must have proper perspective in respect to all his needs, defects and problems. There must first be an acceptance of self if desirable results are to be accomplished.

b. To interpret to parents the significance of the health needs of the child and to encourage their cooperation in seeking treatment.

c. To motivate the student to accept his responsibility in taking steps which are necessary for solving the problem.

d. To encourage pupils and parents to accept responsibility for healthful living habits. To aid them in meeting health needs through self-discovery, self-development and self-management.

e. To provide educational programs for exceptional children which are adapted for their particular needs.

2. As they relate to the community:

a. To encourage the provision of community treatment facilities for pupils from needy families.

b. To encourage pupils and parents to utilize available resources for medical and dental care to the best possible advantage.

c. To provide effective health education to parents which will motivate them to accept greater responsibility for personal and community health.

d. To give better understanding in the community of the school's responsibility to arrange an educational program which will provide all children and youth with an education which is adapted to their particular physical, mental, social and emotional endowments. This will in some meaure help to give parents of children without defects a greater insight into the problems of parents and children with handicapping conditions.

The School Nurse as a Counselor

Over the years the work of nurses in school health programs has changed. Nurses have become better prepared for their work in schools; teachers and othes in education have become more involved in health programs. This widening of interests has resulted in an increasing emphasis on the development of the whole child. There has been an increasing awareness of the relationship between sound physical health and school achievement. Threfore, a team approach has evolved in which all who work in the school share in the responsibility for the school health program and in the well-being of the students.

The particular knowledge, understanding and skills which the qualified school nurse possesses is of inestimable value to the success of the health counseling process. Her relationship to the student and to the family is of a different nature than that of the teacher and can be a valuable tool in gaining confidence and cooperation in solving health problems.

Certain principles and techniques are necessary for a successful health counseling program:

1. Personal Characteristics

a. Interest. The nurse must have a genuine interest in people from the standpoint of service. The desire to help others live a happy successful life and to help eliminate any obstacles to this achievement must be uppermost. The parent and child must know that she sincerely cares about them.

b. Personality. The ability to listen and accept the feelings of others. A friendly, warm manner which conveys a feeling of understanding and respect.

c. Knowledge and competency in counseling skills. This is particularly important for the school nurse whose experiences in hospital clinical situations, where absolute conditions must be observed for the patient's safety, may have resulted in the development of an authoritarian manner. The successful counselor does not tell the parent or student what to do, but rather tries to help him clarify his health problem and lead him to point of discovering what needs to be done. (The development of this particular aspect of personality will prove to be a valuable asset in all relationships, not only in counseling situations.)

2. Preparation for Counseling Situation

a. Gathering of data. All information concerning the child should be reviewed in order that all aspects of the child's life may be discussed. This is useful in establishing rapport. It will indicate a concern for the child and his total environment, not just for the immediate problem.

b. Scheduling. A conference should be unhurried. Choose a time convenient for all who may be involved.

c. Location. Preferably the parent should be invited to the school. The conference should be held in a comfortable, attractive and private surrounding.

d. Participants. Free interchange of ideas and free expression of opinion is to be encouraged. Therefore, it is important to have only those individuals present who have a genuine concern and interest in the particular case. In some instances, it may be desirable for the nurse to contact those who are expected to attend to be certain the time and place is well understood by them.

3. Expected Outcomes of a Health Conference

A mutual understanding as to the next steps to be taken in the elimination or treatment of the health problems.

General Principles

1. Individual counseling of parents and pupils should be given high priority in planning the nurse's school program.

2. Time should be provided for counseling at school and for home visits.

3. Nurse-teacher conferences should be encouraged to assist the teacher in planning for pupils with health problems and to encourage teacher-referrals.

4. Routine pupil-nurse conferences may reveal a health need and can be a valuable adjunct to health education.

5. Close communication and working relationships with guidance counselor, school psychologist and school social worker should be encouraged.

6. Cooperative planning, careful coordination and delineation of responsibilities of nurses, social workers, guidance personnel, etc. is necessary in order to avoid confusion and overlapping of service.

PART IV

FIRST AID AND EMERGENCY CARE

GENERAL RULES FOR CARE OF PUPILS WHO BECOME ILL OR ARE INJURED AT SCHOOL

Boards of Education shall adopt rules and a program of procedures for the care of pupils injured at school and shall require that such rules and program be explained at the beginning of each school year to all employees and copies be posted in each school at points conveniently accessible to the personnel.

As employees of the board of education, school nurses and teachers act under the direction of rules and procedures adopted by the board of education for first aid care of school children who are injured or become ill while under school supervision.

First aid is treatment such as will protect the life and comfort of a child until authorized treatment is secured, and is limited to first treatment only, following which the child is to be placed under the care of his parents, upon whom rests the responsibility for subsequent treatment. Boards of education are not authorized to provide medical or dental care, beyond first aid.

Every school should have written policies for emergency care. Such policies should be developed through cooperative efforts of the school physician, school nurse, parents and the school administrator. Such a program or emergency care should make the following provisions:

1. *Written instructions in simple first aid procedures* to guide those providing emergency care should be developed by the school physician and the school nurse to guide school personnel in the administration of first aid. These instructions should be placed in each classroom, shop, gymnasium and similar work areas.

2. *Persons trained in first aid* should be designated in the order in which they should be called if school nurse is not available.

3. *Emergency Information*

a. A special emergency file for each child should be maintained, and should be readily accessible to responsible school personnel.

Information should be kept current and revised at the start of each school year. This file should include:

(1) Home and business address and telephone numbers of each parent or guardian and two other adults who would assume temporary responsibility in an emergency.

(2) Name, address and telephone number of personal physician and dentist.

(3) Name and telephone number of hospital of choice.

(4) Authorization for school to take the most prudent action in any extreme emergency.

b. *Post in the main office and the health office* the name, address and telephone numbers of the:

(1) School physician
(2) Other physicians to call
(3) Nearest hospital
(4) Ambulance service or other means of transportation.
(5) Police department.

4. *Accident Recording*

After an accident a record should be made immediately in order to ensure accuracy of detail. It is desirable to use a prepared form in order to provide all data. Any accident, however minor, may become subject to litigation. Essential information should include:

Date, time of day, place, witnesses, apparent extent of injury, first aid given, instructions given, and transportation provided.

5. *Plans for transporting pupils home* or to a source of medical attention are the joint responsibility of the school authorities and the parents. In cases of extreme emergency, when school personnel are unable to reach parent or other person designated by the parent as indicated above, the school, acting in place of the parent, is responsible for transporting the child to the source of medical attention.

6. *Ordinarily, the school physician would be responsible for needed emergency care.* In the event of his absence, arrangements should be made with other physicians in the area to provide medical care in emergencies.

7. *First aid supplies,* properly stocked and strategically located, should be checked periodically by the school nurse to ensure that the supplies are adequate in type and amount.

8. *In-service training in first aid procedures.* All adult members of a school should be prepared to render emergency assistance to a school child. The school physician and/or the school nurse should provide such emergency assistance instruction to members of the school staff not already accredited by Red Cross, and should review procedures with them at periodic intervals in order to familiarize them with newer first aid developments. Pupils, as they mature, should be taught to take increasingly more responsibility for the prevention of accidents and emergency care of illness and accidents.

9. *Oral Medication* – The administration of oral medication should be avoided at all times. If circumstances are such that administration is required during the school day, one should question the student's school attendance. Sick children do not belong in school. Unless the medication is prescribed by a physician, it should not be allowed in the school building. Items bought "over the counter" are of doubtful value and their use should be forbidden, not because they may be harmful but for the educational value of such a rule. After careful investigation and the decision to give oral medication has been made, written approval must be obtained from prescribing physician, school physician and the local board of education in the form of adopted policy.

SUGGESTED OUTLINE OF INSTRUCTIONS FOR SCHOOL PERSONNEL FOR EMERGENCY CARE OF PUPILS

(Rules should provide for notification of the principal, parent, family or other physician; immediate care of child; mode of transportation to be provided; escort for the child.)

When a child is injured or is ill at school, the following procedures are suggested:

1. *General*

a. The teacher in charge shall notify the office, keep the child quiet, allay his fears and try to determine how badly he is hurt.

b. The school physician or nurse will take charge if either is available.

c. In the event the school nurse is not available, consult the posted list and contact the next person in order of responsibility.

2. *In case of minor injury* (that does not require services of physician):

a. Notify main office of person in charge of building.

b. Apply simple first aid for superficial cuts and bruises.

c. Call school nurse if available.

d. In absence of nurse, call person designated or qualified to give first aid.

e. Fill out accident reports and deliver to persons designated in the rules of the board of education. A copy should be given to the nurse if she is not present at the time of the accident.

f. It may be advisable to explain details of the injury to the family, either by telephone or a note sent home with the child.

3. *In case of a serious injury:*

   a. Notify main office or person in charge of building.

   b. Emergency treatment should be given in the order of availability by the school physician, nurse, teacher, or other designated person who has had first aid training.

   c. Notify parents in relation to the degree of the injury, if time will permit, so that the parents can advise as to the hospital or physician to which the child shall be taken.

   d. If the parent or responsible person cannot be located, or if the injury is of such serious nature that more than emergency treatment is immediately necessary, see that a child has prompt treatment by a physician or at a hospital. If possible, contact either the school physician or family physician.

   e. If there is bleeding, act immediately to stop it; cover child, keep him warm and reassure him.

   f. Move the child only if necessary and then with great care. The seriousness of an accident may be increased manifold by unwise action at this point.

   g. If the child is to be taken home, be sure someone will be there to receive him. Stay with him until the parent or his representative takes over.

   h. Fill out accident reports and send a copy to each person who has been designated to receive one.

   i. Notify parent of all the circumstances in relation to the accident and treatment.

   j. Notify principal of any action that has been taken.

4. *Illness*

   a. Refer to school nurse, if possible.

   b. Notify main office or person in charge of building.

   c. Pupil should not be taken home unless there is someone to receive him.

   d. Medications should not be given except upon specific written prescription by the school physician.

SUGGESTED AREAS TO BE INCLUDED IN WRITTEN DIRECTIONS FOR EMERGENCY CARE FOR SICKNESS AND ACCIDENTS OCCURRING AT SCHOOL

Bleeding

Nosebleed
Bleeding from Wounds

Burns — Scalds

First Degree (Skin Reddened)
Second Degree (Skin Blistered)
Extensive Second and Third Degree
Chemical Burns

Chronic Illness

Care to be given to children with conditions such as: Diabetes, Epilepsy, Asthma, etc.

Convulsions

Drowning and Electric Shock

Ears

Foreign bodies
Earache

Eyes

Foreign bodies
Chemical burns
Wounds

Fainting

Frostbite

Mouth — Throat

Toothache
Broken teeth
Sore throat
Foreign body in throat

Poisoning by Mouth

Shock

Symptoms
Treatment

Stings — Bites — Poison Oak

Animal, Insect, Snake bites
Poison Oak or Sumac

Suspected Fractures — Head of Spinal Injuries

What *to* do. (call physician etc.)
What *not* to do. (do not move! etc.)
Shock symptoms and Treatment

Transportation of Injured

Recommended procedures and precautions

Wounds — Abrasions

Minor Wounds and Abrasions
Severe Wounds — Control of bleeding

Minor Illness

Headaches, digestive upsets, toothaches, dysmenorrhea, etc.

Note: Standing orders for First Aid and Emergency Care for *Sickness* and *Accidents* occuring at *school* should be compiled by the school physician, superintendent of schools and school nurses together to fit the local situation.

SUGGESTED LIST OF FIRST AID SUPPLIES

Basic Supplies — For Units of 100 Children or Less

Plastic Adhesive Bandages (band-aids) ¾"	Package of 100
Plastic Adhesive Bandages (band-aids) 1"	Package of 100
Sterile Gauze Squares 3" x 3" Individually wrapped. ("Telfa" pad has plastic layer — easy to remove from wound.)	Package of 25
Triangular Bandages For sling — to cover large dressing.	4 bandages
Roller Bandages 1" Finger bandage.	6 rolls
Roller Bandages 2" To hold dressings in place.	6 rolls
Adhesive Tape Roll containing assoreted widths.	1 roll
Tourniquet Wide strip of cloth and short stick — for use in severe bleeding when no other method will control bleeding.	1
Splints ¼" thick, 3½" wide, 12-15" long For fractures. (Plastic splints are available and are preferred by some.)	6

Absorbent Cotton, sterilized	¼ lb. or large box of cotton balls
Applicator Sticks, cotton tip	25
Tongue Blades	150
Ammonia Inhalants	6 ampules
Baking Soda May be used on burns.	1 box
Table Salt For heat exhaustion and soaks.	1 box
Midl Soap-such as Phisohex For cleansing wounds.	4 oz. bottle
Splinter Forceps For removing splinters, stingers, etc.	1
Scissors, blunt end	1 pair
Flashlight	1
Heating Pad, or hot water bottle and cover	1
Ice Bag For local relief of pain and to prevent or reduce swelling. (Small square of moist cloth wrapped in plastic and kept in the freezer are useful for application to small areas.)	1
Eye Dropper For rinsing eyes.	3 droppers
Safety Pins, medium size	24 pins
Red Cross First Aid Textbook (latest edition)	1

Additional equipment may be needed such as: wash basin, container for heating water, small sterilizer, paper drinking cups, thermometer, blankets, stretchers, paper and cloth towels.

No drugs are included in the list of recommended school first aid supplies. Danger of reaction and the possibility of masking pain or other symptoms forbids their administration by school personnel.

First Aid Kits should be available in places where accidents occur frequently – gymnasiums, laboratories, shops and home economics rooms. School buses should be provided with first aid materials.

The recommended list of first aid supplies is meant to serve as a guide. Quantities will vary with the size and type of school and with the availability of medical, ambulance and hospital services. Final selection of materials should be based on recommendations made by the school medical personal and approved by the administrator.

MEDICATIONS

Diagnosis and treatment of illness and prescribing of drugs and medications are not the responsibility of the school.

Recommended policy:

1. The school should not provide students with aspirin or any other medication.

2. Diagnosis or treatment beyond first aid procedure is not usually the responsibility of the school and is legally by non-medical personnel.

3. The administration of medication to pupils shall be done only in exceptional circumstances where in the child's health may be jeopardized without it.

4. Pupils requiring medications at school must have a written statement from the family physician which identifies the type, dosage and purpose of the medication.

5. Written statements from the parents giving permission to give medication prescribed by the family physician should be required by the school.

6. *The school physician must approve any request from a family physician that medication be given a student.*

7. The school physician should be advised of any drug being taken by a child attending school, particularly those which might cause a change in behavior.

Accidents — LEGAL RESPONSIBILITY, PREVENTION, RECORDS

18A:16-6 Indemnity of officers and employees against civil actions.

Whenever any civil action has been or shall be brought against any person holding any office, position or employment under the jurisdiction of any board of education, including any student teacher, for any act or omission arising out of and in the course of the performance of the duties of such office, position, employment or student teaching, the board shall defray all costs of defending such action, including reasonable counsel fees and expenses, together with costs of appeal, if any, and shall save harmless and protect such person from any financial loss resulting therefrom; and said board may arrange for and maintain appropriate insurance to cover all such damages, losses and expenses.

18A:16-6.1. Indemnity of officers and employees in certain criminal actions.

Should any criminal action be instituted against any such person for any such act or omission and should such proceeding be dismissed or result in a final disposition in favor of such person, the board of education shall reimburse him for the cost of defending such proceeding, including reasonable counsel fees and expenses of the original hearing or trail and all appeals.

Liability of Teachers for School Accidents (also applicable to school nurses)

(Excerpts from New Jersey State Safety Council Bulletin on Safety Education)

It must be kept in mind that *liability is a legal result that generally follows negligence. One is always liable for his own negligence.*

Negligence is any conduct which falls below the standard established by law for the protection of others against unreasonable risk or harm. The teacher runs the risk of suit by injured pupils on the basis of alleged negligence which causes bodily injury to pupils. A teacher may be held negligent when she has failed to act as a *reasonably prudent person would act.*

Reasonable prudence consists of the ability to forsee or anticipate trouble or danger under given circumstances. The ability to gauge dangers in terms of anticipation is the basic element of the negligence formula. "Reasonable prudence under the circumstances" is a matter for a *lay jury to decide.*

There are occasions where the teacher must defend himself against an accusation of negligence. The reasoning of the members of a jury is often incomprehensible to those who understand better all the implications of the situation. Teachers, therefore, should be forewarned that never can too much caution be taken to prevent injuries to pupils. If teachers know exactly what is expected of them they can better fit into the legal scheme of affairs and avoid suits, or at least be in a more understanding position for self-defense. It is better to take precautionary measures against accidents than to risk the task of convincing a jury that a particular case did not involve negligence on the part of the teacher.

It is important that school personnel know the status of teachers and nurses, bus drivers, administrators and school boards regarding accidents in connection with any part of the school program. With particular attention to such activities as:

1. Transportation of students — sick or otherwise
2. Athletics
3. Field trips
4. Driver Education
5. School Safety Patrols

Some students may refuse to accept first aid because of certain beliefs which they or their parents hold. It is advisable that local schools should anticipate such problems and obtain legal advice in advance regarding the school's responsibilities and powers.

Accident Reporting and Records

Periodic surveys of accidents as to frequency, type, location and cause should be kept and analyzed for use in the accident prevention program. The use of the nurse in insurance bookkeeping activities *is not to be recommended.*

There is no compulsory sickness or accident insurance in the public schools. In many schools, pupils have an opportunity to purchase accident insurance for a minimal fee. Use of such insurance will help to assure children and youth proper care in case of injury.

Records are important in emergency care programs. Accurate information is often necessary to assist in the settlement of an insurance claim or to protect school personnel against charges of negligence. Such information can be considered reliable only if it was recorded as soon as possible after the incidenct occurred and if it includes all pertinent details as to what happened, what was done to aid the injured and by whom was the emergency care given.

Each school district should adopt a uniform system of accident reporting.

It is recommended that schools adopt the *Standard Student Accident Reporting System* of the National Safety Council. This system has been carefully developed by educators and safety experts and is now used extensively.

Emergency Information Form: At the beginning of each school year an emergency card should be filled out by the parents and returned to the school, where pertinent information should be transferred to the permanent health record. The card can then be kept with the child's permanent school records. This form also contains space for the parents to record inoculations and illness which the child has had in the past year. This may take the place of a health census form.

EMERGENCY INFORMATION

To the Parents or Guardians:

In case of EMERGENCY our procedure will be to contact the parent at home or at work. When this is not possible an ambulance or police car will be called.

You should make arrangements for proper care in case your child should meet with an accident or become too ill to remain in school at a time you are away from home.

1. The school will contact your physician.
2. A designated neighbor or relative may be asked to care for your child until you can be reached.
3. Or the police may be asked to take your child to a hospital emergency service if no other arrangements have been made.

Please complete the other side of this card. This keeps our records up-to-date and speeds emergency care according to your wishes. The school should be notified if your address changes during the school year. Please return this card to your child's teacher as soon as possible.

Principal

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EMERGENCY INFORMATION

Date ____________

Pupil ______________________ School and Grade ____________
last name first middle

Home Address ______________ Telephone No. ____________

Physician's Name ______________ Telephone No. ____________

Dentist's Name ______________ Telephone No. ____________

Brothers and Sisters (names /grades)

__________ __________ __________

__________ __________ __________

Person(s) who will care for child in case parent cannot be reached.

____
Name Address Telephone No.

Alternate ______________________________

Record inoculations and illnesses (and dates) ______________

child has had since start of school last year ______________

______________ ______________
Father's Signature Telephone No. at work

______________ ______________
Mother's Signature Telephone No. at work

ENVIRONMENTAL HEALTH ASPECTS OF HEALTHFUL SCHOOL LIVING

This area includes the physical, social, and emotional factors of the school setting which affect the health, comfort and performance of an individual or group.

All schools have a legal and moral responsibility towards healthful school living to provide wholesome and safe living conditions and democratic social and emotional relationships between teachers, pupils and administrators.

While all members of the staff have responsibilities to foster ideal healthful school living; the school nurse is one key person to be alert for signs of deviations from the normal, thus most helpful in ascertaining the source of trouble and in channeling the problem to the proper authority for evaluation. The nurse also assists with the planning of the school day with reference to health needs of teachers and children. She informs the school administrator and the medical director of environmental conditions in the home which may affect the health of a child and works with the parents in maintaining a healthful home environment. She encourages and promotes health programs for school personnel, including pre-employment and periodic examinations.

Social aspects of school living encourage group living and are designed to develop intelligent, responsible, self-directing citizens. The school should provide a laboratory for this type of development. The school's health program can contribute by maintaining the students' ability to participate effectively in group enterprises; e.g., by teaching them to become familiar with technical vocabulary, by developing a sensitivity to social problems, social conditions, and a respect for the human personality.

The emotional health of children requires that teaching methods give ample opportunity for experiencing success without exposing the child to excessive fatigue, undue worry, or other unfavorable emotional stimulation. Ample periods of rest, relaxation and recreation should be provided for; e.g., the number of extra-curricular activities should be kept to a reasonable limit.

School's Role in Safety

Responsibility for safe and healthful environmental conditions is shared by the school and community. Accidents are now the major threat to the lives of young people – they are the *leading* cause of death among all persons aged 1-36. Among persons of all ages accidents are the *fourth* leading cause of death. Injuries far exceed the number of deaths.

Suffering, expense, permanent handicaps and loss of time emphasize the need for intensified efforts in education for accident prevention.

School administrators have a natural concern for safety for many reasons, such as:

1. personal interest in the well-being of young people;
2. the realization that safety is the product of good education rather than of simple good fortune;
3. absence from school due to injury may result in loss of funds on the basis of average daily attendance;
4. liability due to possible legal action.

The student injury and death rate is based upon all injuries which occur to students while they are under school jurisdiction. This includes injuries which occur while students are enroute to and from school. Therefore, it is important to teach children safe habits and personal responsibility for safety at an early age.

Basic elements of effective school safety and accident prevention programs are:

1. Physical equipment – safe playground and gymnasium facilities.
2. Building design and routine inspection for hazards.
3. Assignment of qualified personnel to supervise student activities.
4. Safety education program in accident prevention for school personnel.
5. Education. Curriculum planning for safety education K-12.
6. Evaluation. Are there complete accident reports? What kind of accidents occur? What kind of injuries occur most frequently? Where?

Responsibilities of the school nurse:

To assist the school physician and administrator in:

1. The establishment of a safety committee to develop safety procedures. This committee should be composed of personnel from the administrative, teaching, special service staff and students.
2. The development of written regulations covering responsibilities of principal, teachers, custodians and other school personnel.
3. The development of written regulations regarding inspection of school buildings, grounds, fire and civil defense drills, accident reporting, first aid procedures, pupil transportation, safety procedures in school shops, gymnasiums, laboratories and playgrounds.

4. The keeping and analyzing of accident reports which will furnish information vital to accident prevention.

5. Safety education to individual students as she provides health services, to help them learn how to prevent future injuries.

6. The interpretation of the safety program to parents through home visits to give better understanding and to obtain their cooperation.

7. She assumes responsibility in helping teachers and other school personnel maintain a safe environment and provide first aid and safety instruction.

HEALTH SUITE

Physical Facilities

The area should be large enough to provide comfort and privacy for children and efficient working conditions for the staff. The health room or suite should be located on the first or ground floor as near the administrative offices as possible. The rooms should be attractively decorated, well lighted with adequate heat and ventilation and ceilings should be accoustically treated. If the facility is to be used by the community, a separate entrance to the outside should be provided so the rest of the school need not be disturbed during such use.

Ideally there should be a suite of rooms rather than one room. Space should be provided for: a reception and waiting room, an examining room, counseling room, resting rooms or cubicles, special screening areas (e.g. vision, hearing, etc.) toilet facilities, office area for health service personnel and records. If only one or two rooms are available, these should be divided by curtains or screens so as to provide privacy for obtaining information, conducting physical examinations and for conferences with child, parent or other personnel.

Special Design Needs and Supplies

1. Waiting Room (300 sq. ft. of floor space)

a. Should have door opening into main corridor.

b. Decorations and furnishings should create a bright and cheerful atmosphere.

c. Doors connecting the waiting room to the rest of the suite should be shielded by screens.

d. Chairs or benches should be available.

e. Bulletin board, table or shelf for exhibits, posters and booklets.

f. Desk or table for record clerk with supplies for making records.

g. Toys for young children.

h. Telephone (when it is deemed necessary).

2. Examining Room

a. Should have a minimum of 200 sq. ft. of floor space. Vision screening may require 22 feet in some instances (i.e. Snellen Chart).

b. In planning new school construction it is recommended that a wall cabinet, counter-top and sink unit be designed to serve as a first aid center and storage supply space. This eliminates the need for a separate cabinet for first aid supplies and conserves space by concentrating first aid and treatment facilities into one area. Electrical outlets should be placed at appropriate areas above the counter in the event sterilizers are needed for special programs.

c. Equipment should include: desk, chair, typewriter, filing cabinets, standard platform scales with measuring rod, movable spotlight, folding screen, blankets and linens (towels etc.), first aid supplies, audiometric and vision testing equipment, cup and towel dispensers, wastebaskets and foot-operated disposal can. Wheel chair and stretchers are often included. A refrigerator is desirable under some conditions.

3. Resting Rooms

a. Should be directly connected with the examining room and toilet facilities.

b. Separate rooms should be provided for each sex with an adequate supply of cots or couches – preferably couches with an adjustable head-rest and plastic upholstery. The number of rest areas is usually determined by school population and location.

c. Bedside tables and wastebaskets

4. Toilet and Washing Facilities

a. Should be accessible to the waiting room, the examining room and the rest areas.

b. A minimum of 48 sq. ft. should be provided for each sex.

5. Dental Health Service Area

a. Should have a floor area of approximately 100 sq. ft.

b. Equipment and facilities are determined by the extent of the dental program.

6. Dressing Room Cubicles

a. Should be 45 sq. ft.

b. Hooks and clothes hangers should be provided in each cubicle.

c. Consideration should be given to interchangeable and multiple use of this space – moveable screens might be used for temporary purposes in order to get best possible utilization of space in the health suite.

HEALTH EDUCATION MATERIALS

There are many general sources of information available for those who work in the fields of health services and health education. It is impossible to separate health education from health services. Therefore, the school nurse has a responsibility to keep informed as to the available channels of information and to utilize them to the best advantage.

In making requests for materials, there are certain kinds of details which any agency would probably need before it could fill the request satisfactorily:

1. Who – Individual for whom its use is intended, i.e., school children, parents, nurses, etc. . .
2. What – Pamphlet, leaflet, film, radio program, exhibit, how many, etc. . .
3. When – Date most desirable, alternate date, how long will it be needed?
4. Where – How much and what kind of space is available – wall space, table tops, store windows?
5. Why – Purpose. What main points do you want to cover?

How the request is made is almost as important as whether the request is made at all. Better results are obtained when there is little doubt as to the specific purpose and kinds of materials which will be suitable.

GENERAL INFORMATION SOURCES

A partial list of national sources follows. No attempt has been made to list specific materials offered by these sources, but in many cases catalogs are available and in most cases the name of the agency will indicate the subject matter and scope of its material. It should be understood that not all of these materials are free.

American Association for Health,
Physical Education and Recreation
1201 Sixteenth Street, N.W., Washington 6, D.C.
Pamphlets, lists and movies.

American Cancer Society
Director of Public Education
521 W. 57th Street, New York 19, N.Y.
Films, pamphlets, posters, exhibits, TV materials, radio scripts and transcriptions.

American Dental Association
Bureau of Dental Health Education
222 E. Superior Street, Chicago 11, Ill.
Pamphlets, charts, posters, models.

American Diabetes Association
1 E. 45th Street, New York 17, N.Y.
"A.D.A. Forecast," bimonthly magazine, reprints, pamphlets.

American Heart Association
Inquiries Section
44 E. 23rd Street, New York 10, N.Y.
Films, slide films, pamphlets, posters, exhibits, list of publications.

American Institute of Baking
Consumer Service Department
400 E. Ontario, Chicago, Ill.
Pamphlets, posters (classroom quantities free).

American Medical Association
Bureau of Health Education
535 N. Dearborn Street, Chicago 10, Ill.
Films, pamphlets, posters, exhibits, radio transcriptions, television scripts, packets, lists and the magazine "Today's Health."

American National Red Cross
Office of Public Information
Washington 13, D.C.
Films, pamphlets, posters, exhibits, radio scripts, transcriptions, catalogs, lists.

American Nurses' Association
10 Columbus Circle, New York, N.Y. 10019
Pamphlets, reprints, films, slide films, booklets.

American Public Health Association
1790 Broadway, New York 19, N.Y.
Reports on education qualifications of health workers, community survey guide, list of publications and reprints.

American Social Hygiene Association
Division of Public Information
1790 Broadway, New York 19, N.Y.
Pamphlets, exhibits, lists.

Association for the Aid of Crippled Children
Division of Publications and Public Education
345 E. 46th Street, New York 17, N.Y.
Pamphlets, reprints, exhibits, lists, movies, books.

Association for Physical and Mental Rehabilitation
1472 Broadway, New York 36, N.Y.
Pamphlets, reprints, a journal.

Better Vision Institute, Inc.
630 Fifth Avenue, New York 20, N.Y.
Pamphlets, alive sound films, movies.

Borden Company
Consumer Services
350 Madison Avenue, New York, N.Y.
Pamphlets.

Bristol-Myers Company
Educational Service Department
630 Fifth Avenue, New York, N.Y.
Pamphlets, posters.

Cereal Institute, Inc.
Educational Director
135 S. LaSalle Street, Chicago 3, Ill.
Elementary and high school classroom teaching units.

Child Study Association of America
132 E. 74th Street, New York 21, N.Y.
Pamphlets, publication and book lists.
Leaflet on organizing a parent education program.

Committee on Careers
National League for Nursing
2 Park Avenue, New York 16, N.Y.
Pamphlets, posters, radio scripts, slide films, cartoons, exhibits, lists, movies.

Equitable Life Assurance Society of the United States
Bureau of Public Health
393 Seventy Avenue, New York 1, N.Y.
Booklets, posters, related material.

Florida Citrus Commission
Lakeland, Fla.
Pamphlets, posters, movies.

General Mills
Education Section, Department of Public Services
400 Second Avenue, S., Minneapolis 1, Minn.
Nutrition-education teaching aids.

Health Information Foundation
Public Relations Director
420 Lexington Avenue, New York 17, N.Y.
Pamphlets, bulletins, transcriptions, films.

John Hancock Mutual Life Insurance Co.
Health Education Service
200 Berkeley Street, Boston 17, Mass.
Pamphlets, lists.

Metropolitan Life Insurance Company
Health and Welfare Division
1 Madison Avenue, New York 10, N.Y.
Pamphlets, exhibits, films, filmstrips, catalogs.

National Association for Mental Health
Director of Education and Program Services
10 Columbus Circle, New York 19, N.Y.
Pamphlets, posters, radio scripts, transcriptions, catalogs, exhibits, films, dramatic sketches.

National Dairy Council
Program Service Department
111 N. Canal Street, Chicago 6, Ill.
Health education materials, catalog listing booklets, posters, films, filmstrips, exhibits, displays.

National Foundation, The
Director of Public Education
800 Second Avenue, New York, N.Y. 10017
Pamphlets, booklets, films, filmstrips, exhibits, bibliographies.

National Health Council
1790 Broadway, New York 19, N.Y.
Pamphlets, reprints, leaflets, list of publications, health career materials.

National Heart Institute
Heart Information Center
Bethesda 14, Md.
Pamphlets, etc.

National League for Nursing, Inc.
Director of Public Relations
2 Park Avenue, New York 16, N.Y.
Leaflets, pamphlets, reprints, bibliographies, books, handbooks, posters, films, slides.

National Publicity Council for Health and Welfare
257 Fourth Avenue, New York 10, N.Y.
Newsletter, library of health education materials.

National Safety Council
Director of Public Information
425 N. Michigan Avenue, Chicago 11, Ill.
Films, pamphlets, posters, cartoons, catalogs.

National Society for the Prevention of Blindness
Director of Information Service
1790 Broadway, New York 19, N.Y.
Films, pamphlets, posters, exhibits, radio scripts, catalogs, vision testing charts.

National Tuberculosis Association
1790 Broadway, New York 19, N.Y.
Films, filmstrips, pamphlets, posters, exhibits, TV spots, radio scripts, transcriptions, catalogs.

Public Affairs Pamphlets
22 E. 38th Street, New York 16, N.Y.
Popularly written pamphlets on a variety of subjects in health and social welfare field.

Tampax, Inc.
Educational Director
161 E. 42nd Street, New York 17, N.Y.
Pamphlets, anatomical charts (17" x 22") and model, lists, menstrual health reference material.

U.S. Children's Bureau
Division of Reports
Washington 25, D.C.
Pamphlets, catalogs, lists.

U.S. Department of Agriculture
Human Nutrition, Research Branch
Washington 25, D.C.
Pamphlets, radio scripts, exhibits, lists, movies.

U.S. Public Health Service
Department of Health, Education and Welfare
School Health Section, Bureau of State Services
Washington 25, D.C.
Leaflets and pamphlets.

SOME GENERAL REFERENCES IN SCHOOL HEALTH SERVICES

1. SUGGESTED SCHOOL HEALTH POLICIES National Education Association and American Medical Association, 1966, either 1201 Sixteenth Street, N.W., Washington, D.C., 20006 or 535 North Dearborn Street, Chicago, Illinois 60616.

2. RESPONSIBILITIES OF STATE DEPARTMENTS OF EDUCATION AND HEALTH FOR SCHOOL HEALTH SERVICES National Council of Chief State School Officers and Association of State and Territorial Health Officers, 1959.

3. TEAMWORK IN SCHOOL HEALTH 1962, American Association for Health, Physical Education, and Recreation of the National Education Association, 1201 Sixteenth Street, N.W., Washington, D.C., 20006.

4.SCHOOL HEALTH SERVICES Joint Committee NEA-AMA, 1201 Sixteenth Street, N.W., Washington, D.C. or 535 Dearborn Street, Chicago, Illinois.

5. SCHOOL HEALTH PROGRAM Hagg, Jessie Helen, San Francisco: Holt, Rinehart, and Winston, Inc., 1965, pp. 395 (revised edition).

6. THE SCHOOL HEALTH PROGRAM Ne-mir, Alma, M.D., Philadelphia: W. B. Saunders Company, 1965, pp. 410, $7.75 (second edition).

7. SCHOOL HEALTH ADMINISTRATION Byrd, Oliver E., Ed.D., M.D., Philadelphia: W. B. Saunders Company, 1964, pp. 485.

8. SCHOOL HEALTH PRACTICE Anderson, G. L., Dr. P.H., St. Louis: The C.V. Mosby Company, 1964, pp. 544, (third edition).

9. HEALTH OBSERVATION OF SCHOOL CHILDREN Wheatley, George and Hallock, Grace, New York City: McGraw-Hill, 1965, pp. 527, (third edition).

10. SCHOOL HEALTH PROBLEMS Volume 12, Number 4 of the Pediatric Clinics of North America, November 1965, W.B. Saunders Company.

11. COMMUNITY HEALTH SERVICES Wilbur, W.B. Saunders Company, Philadelphia: 1962, pp. 364.

12. HEALTH OF CHILDREN OF SCHOOL AGE Children's Bureau Publication #427, U.S. Department of HEW, U.S. Government Printing Office, Washington, D.C., 20402 (second printing 1965) 25¢.

13. MINIMAL BRAIN DYSFUNCTION IN CHILDBIRTH 1966, Public Health Service publication #1415, Superintendent of Documents, U.S. Government Printing Press, Washington, D.C. 20402, 20¢.

14. HEALTH AND THE COMMUNITY Katz, Alfred and Felton, Jean, University of California Los Angeles, Free Press, Front and Broom Street, Riverside, New Jersey.

15. EMOTIONAL PROBLEMS OF ADOLESCENTS Gallagher and Harris, Oxford University Press, New York: 1966.

16. ADOLESCENTS AND THE SCHOOLS James Coleman, Basic Books, Fourth Avenue, New York City, 165, pp. 121.

17. REVIEW OF EDUCATION RESEARCH December 1965 issue ("Education for socially disadvantaged children," including papers on language development, learning disabilities, and remedial programs.)

18. PREVENTIVE MEDICINE Hilleboe, HERMAN E., M.D., and Larimore, Granville W., M.D., W.B. Saunders Co., 1965, pp. 523 illustrated, (second edition).

19. REPORT OF THE COMMITTEE ON SCHOOL HEALTH OF THE AMERICAN ACADEMY OF PEDIATRICS American Academy of Pediatrics, P.O. Box 1034 Evanston, Illinois 60204, 1966.

20. THE MANAGEMENT OF HEALTH PROBLEMS OF SECONDARY SCHOOL STUDENTS Simon, Helen M., Teachers College Press, Teachers College, Columbia University, New York, New York. 1968.

PART V

SCHOOL LAWS AND STATE BOARD OF EDUCATION RULES AND REGULATIONS FOR HEALTH

Chapter 40. Promotion of Health and Prevention of Disease.

ARTICLE 1. MEDICAL AND NURSING PERSONNEL

18A:40-1. Employment of medical inspectors, optometrists and nurses; salaries; terms; rules

Every board of education shall employ one or more physicians, licensed to practice medicine and surgery within the state, to be known as the medical inspector or medical inspectors, and any board, not furnishing nursing services under a contract pursuant to section 18A:40-3.1 shall employ one or more school nurses, and it may also employ one or more optometrists, licensed to practice optometry within the state, to be known as the school vision examiner or school vision examiners, and the board shall fix their salaries and terms of office.

Every board of education shall adopt rules, subject to the approval of the state board, for the government of such employees. Source: R.S.18:14-56, amended 1947, *c.* 148, s. 23; 1952, *c.* 127; 1965, *c.* 223, s. 1.

18A:40-3. Lectures to teachers

A medical inspector or nurse shall lecture to the teachers at such times as may be designated by the board of education instructing them concerning the methods employed to detect the first signs of communicable disease and the recognized measures for the promotion of health and the prevention of disease. Source: R.S. 18:14-58.

18A:40-3.1 Appointment and salary, school nurses, etc.

Every person employed as a school nurse, school nurse supervisor, head school nurse, chief school nurse or school nurse coordinator, or performing any school nursing service, in the public schools of this state shall be appointed by the board of education having charge of the school or schools in which the services are to be rendered and shall be under the direction of said board or an officer or employee of the board designated by it and the salary of such person shall be fixed by, and paid from the funds of said board according to law, except that the performance of school nursing services in any public school in this state may be continued, under any original contract or agreement entered into, prior to February 27, 1957, or under any renewal or modification thereof, during the term of such contract or agreement or renewal or modification thereof. Source: C. 18:14-56.4 (1956, c. 233, s.1).

ARTICLE 2. EXAMINATION OF PUPILS

18A:40-4. Examination of pupils; health records

The medical inspector, or the nurse under the immediate direction of the medical inspector, shall examine every pupil to learn whether any physical defect exists, or in lieu thereof the medical inspector may accept the report of such an examination by a physician licensed to practice medicine and surgery within the State. The frequency and procedure of and selection of pupils for such examinations shall comply with the rules of the State Board, but a pupil who presents a statement signed by his parent or guardian that a medical examination interferes with the free exercise of his religious beliefs shall be examined only to the extent necessary to determine whether he is ill or infected with a communicable disease or to determine his fitness to participate in any health, safety and physical education course required by law. A health record of each pupil shall be kept, in which shall be entered the findings of each examination, and such record shall be the property of the board of education and shall be forwarded to any public school to which the pupil is transferred, if such school is known. *Source:* R.S. 18:14-57, amended 1955, c. 25, and 1969, c. 40.

18A:40-5. Method of examination; notice to parent or guardian

In conducting such examinations of pupils the medical inspector may require pupils to loosen, open, or remove their clothing above the waist in a manner to facilitate inspection and examination, but in any such case the parents or guardians shall be notified in writing of such proposed examination and in such notice the presence of one of the parents or guardians shall be requested, and it shall be stated in the notice that in the absence of a parent or guardian there shall be present a nurse or teacher and in the examination of a female pupil the nurse or teacher present shall be of the female sex, and that if the parent or guardian objects to such examination, then the parent or guardian may file with the medical inspector a report of the family physician upon the condition for which such examination was deemed advisable by the medical inspector. *Source:* C. 18:14-57.1 (1959, c. 296).

ARTICLE 3. HEALTH MEASURES IN GENERAL

18A:40-6. In general

The board of education of any district may provide such equipment, supplies, and services as in its judgment will aid in the preservation and promotion of the health of the pupils, subject to the provisions of section 18A:18-5.1. *Source:* R.S. 18:11-14, amended 1947, c. 148, s. 19; 1957, c. 51; 1964, c. 193, s.

18A:40-7. Exclusion of pupils who are ill

When there is evidence of departure from normal health of any pupil, the principal of the school shall upon the recommendation of the school physician or school nurse exclude such pupil from the school building, and in the absence from the building of the school physician or school nurse, the classroom teacher may exclude the pupil from the classroom and the principal may exclude the pupil from the school building. *Sourse:* R.S. 18:14-59.

18A:40-8. Exclusion of pupils whose presence is detrimental to health and cleanliness

The principal may, upon the recommendation of the school physician or the school nurse, if either of them are present in the building, exclude from school any pupil who has been exposed to a communicable disease or whose presence in the school room certified by the medical inspector as detrimental to the health or cleanliness of the pupils in the school, and in the absence from the building of the school physician or school nurse, the classroom teacher may exclude the pupil from the classroom and the principal may exclude the pupil from the school building and the principal or the classroom teacher, as the case may be, shall notify the parent, guardian or other person having control of the pupil of the reason for his exclusion. *Source:* R.S. 18:14-60.

18A:40-9. Failure of parent to remove cause for exclusion; penalty

If the cause for exclusion under this article is such that it can be remedied, and the parent, guardian or other person having control of the pupil excluded shall fail within a reasonable time to have the cause for the exclusion removed, the parent, guardian or other person shal be proceeded against, and upon conviction, be punishable as a disorderly person. *Source:* R.S. 18:14-61.

18A:40-10. Exclusion of teachers and pupils exposed to disease

No teacher or pupil who is a member of a household in which a person is ill with smallpox, diphtheria, scarlet fever, whooping cough, yellow fever, typhus fever, cholera, measles, or such other contagious or infectious disease as may be designated by the board of education, or of a household exposed to contagion as aforesaid, shall attend any public school during such illness, nor until the board of education has been furnished with a certificate from the board of health, or from the physician attending such person, or from a medical inspector, certifying that all danger of communicating the disease by the teacher or pupil has passed. *Source:* R.S. 18:14-54.

18A:40-11. Exclusion of pupils having tuberculosis

Any pupil found to have tuberculosis in an active or a communicable stage shall be excluded from school and a report of each such case shall be filed by the school medical inspector with the health officer of the secretary of the board of health of the municipality in which the pupil resides. Readmission to school may be granted when proof satisfactory to the school medical inspector is furnished to indicate that the pupil is free from communicable tuberculosis, is physically competent to engage in school activities, and is not a menace to the health of other pupils. *Source:* C. 18:14-64.8 (1939, c. 294, s. 4).

18A:40-12. Closing schools during epidemic

Whenever the board of health of any municipality shall declare any epidemic or cause of ill health to be so injurious or hazardous as to make it necessary to close any or all of the public schools in the municipality, the board shall immediately serve notice on the board of education of the school district situated in the municipality that it is desirable to close the school or schools. Upon receipt of the notice the board of education may close the schools under its control, or such of them as may be designated by the board of health. The schools so closed shall not be reopened until the board of education is satisfied that all danger from the epidemic or cause of ill health has been removed. *Source:* R.S. 18:14-55.

18A:40-12.1 Protective eye devices required for teachers, pupils and visitors in certain cases

The board of education of every school district shall require each pupil and teacher in the public schools of the district to wear industrial quality eye protective devices while attending classes in vocational or industrial art shops or laboratories in which caustic or explosive chemicals, hot liquids or solids, hot molten metals, or explosives are used or in which welding of any type, repair or servicing of vehicles, heat treatment or tempering of metals, or the milling, sawing, stamping or cutting of solid materials, or any similar dangerous process is taught, exposure to which might have a tendency to cause damage to the eyes. Visitors to such classrooms or laboratories shall also be required to wear such protective devices. *Source:* C. 18:14-109.1 (1965, c. 159, ss. 1, 2).

18A:40-12.2. Rules prescribing kinds — types and quality of devices

The commissioner, by rule or regulation, shall prescribe the kinds, types and quality of such protective devices and in so doing, the commissioner shall be guided by the standards promulgated by the American Standards Association, Inc. for such protective devices. *Source:* C. 18:14-109.1 (1965, c. 159, ss. 1, 2).

ARTICLE 4. IMMUNIZATION AGAINST, AND TREATMENT OF, SPECIFIC DISEASES

A. DIPHTHERIA

18A:40-13. Immunization to diphtheria; exemptions

The board of education of any school district may require immunization to diphtheria as a prerequisite to attendance at school, and it may at its discretion require or waive proof of immunity, except as hereinafter provided.

Any pupil failing to comply with such a requirement may be excluded from school, unless the pupil shall present a certificate signed by a physician stating that the pupil is unfit to receive the immunizing treatment, or a certificate signed by a physician or by the board of health or the health officer of the municipality in which the pupil resides to the effect that the pupil is known by evidence of an appropriate test to be immune to diphtheria; provided, that in either or any such instance the certification and the test employed shall have the approval of the school medical inspector.

A board of education may exempt a pupil from the provisions of this section if the parent or guardian of said pupil objects thereto in a written statement signed by him upon the ground that the proposed immunization interferes with the free exercise of his religious principles. *Source:* C. 18:14-64.2 (1939, c. 299, s. 1, amended 1952, c. 153).

18A:40-14. Immunization, etc., at public expense

A board of education may provide the necessary equipment, materials and services for immunizing, to diphtheria, pupils whose parents or guardians in the opinion of the board are unable to meet the necessary expense; and, further, when proof of immunity thereto is included in the requirement, a board of education may provide the necessary equipment, materials, and services for testing any or all pupils to determine susceptibility to diphtheria or to measure the effectiveness of the immunizing treatment *Source:* C. 18:14-64.3 (1939, c. 299, s. 2).

18A:40-15. Pupils who have had diphtheria; treatment

The board of education shall require any child or pupil who has had diphtheria and who can furnish proof to that effect satisfactory to the medical inspector to submit first to a test of immunity, and, if by this means immunity is established, he shall not be required to undergo the immnization procedure, but if the test reveals susceptibility to diphtheria he shall be subject to such requirement of immunization. *Source:* C. 18:14-64.4 (1939, c. 299, s. 3).

B. TUBERCULOSIS

18A:40-16. Tuberculosis; determining presence of

The board of education of every school district shall periodically determine or cause to be determined the presence or absence of active or communicable tuberculosis in any or all pupils in public schools, and, with respect to frequency, procedure, and selection of pupils, shall comply with the rules of the state board. *Source:* C. 18:14-64.5 (1939, c. 294, s. 1).

18A:40<17. Equipment, materials and services for tuberculosis tests

The board may provide at its expense the equipment, materials, and services necessary to make such determination, or it may contract to use for that purpose, with or without financial reimbursement, the equipment, materials, and services available through a sanitorium or hospital approved by the state department of institutions and agencies or through a public health agency approved by the state department of health. *Source:* C. 18:14-64.6 (1939, c. 294, s. 2).

18A:40-18. Exclusion of pupils failing to comply with rules and orders

Any pupil failing to comply with the rules of the board of education relating to the determination of the presence of tuberculosis or any order issued by a school officer pursuant to such rules shall be excluded from school. *Source:* C. 18:14-64.7 (1939, c. 294, s. 3).

18A:40-19. Records and reports relating to tuberculosis; disposition of; examination

All records and reports of tuberculosis case-finding procedures conducted by or under the auspices of a board of education shall be the property of the board and shall be filed with the medical inspector as confidential information except that such records and reports shall be open for inspection by officers of the state department of health and of the local board of health, of the municipality in which the pupil resides and of the municipality in which the school is located. *Source:* C. 18:14-64.9 (1939, c. 294, s. 5).

C. VACCINATIONS

18A:40-20. Vaccination at public expense

A board of education may provide the necessary equipment, materials and services for vaccinating pupils whose parents or guardians are, in the opinion of the board, unable to meet the necessary expense of vaccination. *Source:* R.S. 18:14-53.

18A:40-21. Exclusion of teachers and pupils for lack of vaccination; exemption

A board of education may exclude from school any teacher or pupil who has not been successfully vaccinated or revaccinated, unless the teacher or pupil shall present a certificate signed by a physician stating that the teacher or pupil is an unfit subject for vaccination, provided that the certification shall have the approval of the school medical inspector. A board of education may exempt a teacher or pupil from the provisions of this section, if said teacher or the parent or guardian of said pupil objects thereto in a written statement signed by him upon the ground that the proposed vaccination interferes with the free exercise of his religious principles. *Source:* R.S. 18:14-52, amended 1952, c. 152.

D. POLIOMYELITIS; MEASLES

18A:40-22. Immunization against poliomyelitis or measles

The board of education of a school district may require all pupils to have received immunizing treatment against poliomyelitis or measles, or both, as a prerequisite to attendance at school and it may exclude from school any pupil failing to comply with such requirement, unless the pupil shall present a certificate signed by a physician stating that the pupil is unfit to receive such immunizing treatment or, in the case of measles, has had clinical measles or a written statement, signed by his parent or guardian, that the proposed immunization interferes with the free exercise of the pupil's religious principles. The board may, at its discretion, require or waive proof of immunity, except as hereinbefore provided. *Source:* C. 18:14-64.10 (1957, c. 133, s. 1, amended 1967, c. 178).

18A:16-2. Physical examinations; requirement

Every board of education shall require all of its employees, and may require any candidate for employment, to undergo a physical examination, the scope whereof shall be determined under rules of the state board, at least once in every year and may require additional individual psychiatric or physical examination of any employee, whenever, in the judgment of the board, an employee shows evidence of deviation from normal, physical or mental health.

Any such examination may, if the board so requires, include laboratory tests or fluoroscopic or X-ray procedures for the obtaining of additional diagnostic data. *Source:* C. 18:5-50.5 (1939, c. 295, amended 1954, c. 262).

18A:16-3. Character of examinations

Any such examination may be made by a physician or institution designated by the board, in which case the cost thereof and of all laboratory tests and fluoroscopic or X-ray procedures shall be borne by the board or, at the option of the employee, they may be made by a physician or institution of his own choosing, approved by the board, in which case said examination shall be made at the employee's expense. *Source:* C. 18:5-50.5 (1939, c. 295, amended 1954, c. 262).

18A:16-4. Sick leave; dismissal

If the result of any such examination indicates mental abnormality or communicable disease, the employee shall be ineligible for further service until proof of recovery, satisfactory to the board, is furnished, but if the employee is under contract or has tenure, he may be granted sick leave with compensation as provided by law and shall, upon satisfactory recovery, be permitted to complete the term of his contract, if he is under contract, or be re-employed with the same tenure as he possessed at the time his services were discontinued, if he has tenure, unless his absence shall exceed a period of two years. *Source:* C. 18:5-50.5 (1939, c. 295, amended 1954, c. 262).

18A:16-5. Records of examinations

All records and reports relating to any such examination shall be the property of the board and shall be filed with its medical inspector as confidential information but shall be open for inspection by officers of the state department of health and the local board of health. *Source:* C. 18:5-50.5 (1939, c. 295, amended 1954, c. 262).

18A:16-6. Indemnity of officers and employees against civil actions

Whenever any civil action has been or shall be brought against any person holding any office, position or employment under the jurisdiction of any board of education, including any student teacher, for any act or omission arising out of and in the course of the performance of the duties of such office, position, employment or student teaching, the board shall defray all costs of defending such action, including reasonable counsel fees and expenses, together with costs of appeal, if any, and shall save harmless and protect such person from any financial loss resulting therefrom; and said board may arrange for and maintain appropriate insurance to cover all such damages, losses and expenses. *Source:* C. 18:5-50.4a (1965, c. 205, s. 1, amended 1967, c. 167, s. 1).

18A:16-6.1. Indemnity of officers and employees in certain criminal actions

Should any criminal action be instituted against any such person for any such act or omission and should such proceeding be dismissed or result in a final disposition in favor of such person, the board of education shall reimburse him for the cost of defending such proceeding, including reasonable counsel fees and expenses of the original hearing or trial and all appeals. *Source:* C. 18:5-50.4b (1965, c. 205, s. 2, amended 1967 C. 167, s. 2).

18A:28-4. Teaching staff members not certified, not to obtain tenure; exception

No teaching staff member shall acquire tenure in any position in the public schools in any school district or under any board of education, who is not the holder of an appropriate certificate for such position, issued by the state board of examiners, in full force and effect, except that no board of education shall terminate the employment or refuse to continue the employment or re-employment of any school nurse appointed prior to May 9, 1947 for the reason that such nurse is not the holder of such a certificate and the state board of examiners shall make no rule or regulation which will affect adversely the rights of any such nurse under any certificate issued prior to said date.

Source: R.S. 18:13-16, amended 1940, c. 43; 1952, c. 236, s. 12; 1962, c. 231, s. 1. C. 18:14-56.3 (1947, c. 133, s. 3); C. 18:14-64.1a (1957, c. 181, s. 1); C. 18:14-64.1b (1957, c. 181, s. 2, amended 1960, c. 137, s. 7).

18A:28-5. Tenure of teaching staff members

The services of all teaching staff members including all teachers, principals, assistant principals, vice principals, superintendents, assistant superintendents, and all school nurses including school nurse supervisors, head school nurses, chief school nurses, school nurse coordinators, and any other nurse performing school nursing services and such other employees as are in positions which require them to hold appropriate certificates issued by the board of examiners, serving in any school district or under any board of education, excepting those who are not the holders of proper certificates in full force and effect, shall be under tenure during good behavior and efficiency and they shall not be dismissed or reduced in compensation except for inefficiency, incapacity, or conduct unbecoming such a teaching staff member or other just cause and then only in the manner prescribed by subarticle B of article 2 of chapter 6 of this title, after employment in such district or by such board for:

(a) three consecutive calendar years, or any shorter period which may be fixed by the employing board for such purpose; or

(b) three consecutive academic years, together with employment at the beginning of the next succeeding academic year; or

(c) the equivalent of more than three academic years within a period of any four consecutive academic years;

provided that the time in which such teaching staff member has been employed as such in the district in which he was employed at the end of the academic year immediately preceding July 1, 1962, shall be counted in determining such period or periods of employment in that district or under that board but no such teaching staff member shall obtain tenure prior to July 1, 1964 in any position in any district or under any board of education other than as a teacher, principal, assistant superintendent or superintendent, or as a school nurse, school nurse supervisor, head school nurse, chief school nurse, school nurse coordinator, or as the holder of any position under which nursing services are performed in the public schools.

Source: R.S. 18:13-16, amended 1940, c. 43; 1952, c. 236, s. 12; 1962, c. 231, s. 1; 18:13-17, amended 1952, c. 236, s. 13; 1960, c. 137, s. 5; 1962, c. 231, s. 2; C. 18:14-64.1a (1967, c. 181, s. 1); C. 18:14-64.1b (1967, c. 181, s. 2, amended 1960, c. 137, s. 7).

18A:28-14. Teaching staff members not certified; not protected; exception

The services of any teaching staff member who is not the holder of an appropriate certificate, in full force and effect, issued by the state board of examiners under rules and regulations prescribed by the state board of education may be terminated without charge or trial, except that any school nurse appointed prior to May 9, 1967 shall be protected in her position as is provided in section 18A:28-4 of this title. *Source:* C. 18:14-64.1c (1967, c. 181, s. 3).

18A:35-4. Course in nature and effect of alcoholic drinks and narcotics

The nature of alcoholic drinks and narcotics and their effects upon the human system shall be taught in all schools supported wholly or in part by public moneys in such manner as may be adapted to the age and understanding of the pupils and shall be emphasized in appropriate places of the curriculum sufficiently for a full and adequate treatment of the subject. *Source:* R.S. 18:14-86, amended 1954, c. 81, s. 7.

18A:43-1. Accident insurance for pupils authorized

The board of education in any school district may arrange for and maintain, and may pay the premiums for policies of accident insurance with any insurance company created by or under the laws of this state or authorized by law to transact business in this state, to provide for payments to pupils of the school district in connection with loss resulting from bodily injury sustained by such pupils through accidental means while participating in, practicing or training for, or during transportation to or from games or contests conducted by the school district, or by any school of the district, or with the consent of the board of education or of the school and under the supervision of an employee of the board of education, and for payments to pupils injured in connection with the conduct of the physical education program of the district. *Source:* C. 18:14-105.1 (1947, c. 130, s. 1).

18A:43-2. Payment by pupils of proportionate share of premiums

A board of education maintaining such accident insurance for the benefit of its pupils may require the payment to the board of education by pupils to whom the benefit of such insurance is extended, of a proportionate share of the premiums or any part thereof. The sums to be paid by the pupils shall be established by a schedule determined by the board of education, but no pupil electing not to participate in the accident insurance coverage, shall be required to make any payment toward the cost of the premiums therefor. *Source:* C. 18:14-105.2 (1947, c. 130, s. 2).

18A:43-3. No liability imposed on board of education

The provisions of this chapter shall not be construed to impose any liability on the part of a board of education for injury sustained by a pupil as a result of or in connection with any of the games or contests hereinabove mentioned, or as a result of or in connection with the conduct of the physical education program of the school district or of any school of the district. *Source:* C. 18:14-105.3 (1947, c. 130, s. 3).

STATE BOARD OF EDUCATION RULES AND REGULATIONS
HEALTH, SAFETY AND PHYSICAL EDUCATION

1. School Health Services (pursuant to R.S. 18A:40-1)

Every board of education in this state shall adopt rules to govern health services in its school district and such rules and regulations shall include as a minimum the rules and regulations of the state Board of Education which are expressed in the following sections.

a. *School Health Examination (implementing R.S. 18A:40-1)*

(1) Every board of education in this state shall appoint at least one medical inspector.

(2) The medical inspector shall direct the professional duties or activities of the school nurse and shall compile and issue regulations governing professional techniques, the conduct of inspections or tests, and the administration of treatment.

(3) Boards of education, medical inspectors, any medical specialist employed by a school board, school dentists, teachers of health, and nurses shall at all times comply with the rules and regulations of the local boards of health and of the State Department of Health which relate to the sanitation of public grounds and buildings and to the prevention and control of communicable diseases.

(4) Medical inspectors shall omit dental examinations in making physical examinations of pupils who have been or will be examined by a school dentist in the current school year.

(5) For beginning pupils, medical inspectors may accept a record of a thorough physical examination made by a family physician or by a physician working under a plan for the examination of pre-school children, provided that the plan and the records or reports used in either type of examination have been approved by the State Board of Education.

(6) If a board of education requires the medical inspector to undertake special work not included in these rules or required by statute, the board shall enter into an agreement with the medical inspector concerning such additional duties.

(7) Each medical inspector shall record the results of examinations upon a record form recommended by the Commissioner of Education. Such form shall be kept in a permanent file and shall be the property of the board of education and shall be preserved. The individual health record shall be forwarded with other school records of pupils who transfer to another school district. If a child leaves school for any other reason, the record shall remain the property of the school.

(8) The results of health examinations or of emergency treatment administered or recommended by the medical inspector shall be *reported to parents*, upon forms provided for the purpose by the board of education.

(9) Boards of education shall submit reports of medical examinations to the Commissioner of Education at times and in the form prescribed by the Commissioner.

b. Nursing Service (implementing R.S. 18:14-58)

(1) All nurses engaged in any capacity in the public school shall comply with the rules and regulations of the local board or boards of education having jurisdiction, and shall be subject to the administrative authority of such school and school districts.

c. Prevention and Control of Communicable Diseases
(implementing R.S. 18:14-52 - 55; 18:14-58 [illegible])

(1) The rules of a board of education pertaining to the prevention and control of communicable disease in schools shall be distributed to all principals, medical inspectors, and nurses, and the rules shall be explained by the health service staff to the entire school personnel at the beginning of each school year.

(2) Any pupil who appears to be ill or who is suspected of having a communicable disease shall be excluded from school or isolated at school to await instructions from or the arrival of an adult member of his family, the medical inspector, or the nurse.

(3) Any pupil retained at home or excluded from school by reason of having or suspected of having a communicable disease shall not be readmitted to his classroom until he presents a written certificate of good health from a regularly qualified physician who has examined or attended him.

(4) The rules of the local board of health or the State Department of Health pertaining to communicable diseases among school children shall apply in determining periods of incubation, communicability, and quarantine and in excluding or readmitting pupils known to have had or suspected of having had contact with cases of communicable diseases.

(5) Medical inspectors shall comply with the regulations of the State Department of Health concerning the reporting of communicable diseases.

d. Dental Health Service (Pursuant to R.S. 18A:4-15)*

(1) The school dentist shall direct the professional duties or activities of the dental assistant or of the nurse assigned to the dental service.

(2) Reparative dentistry shall be limited to pupils whose parents indicate consent to such treatment upon a form provided for the purpose by the board of education and filed with the school principal, but in no case shall a pupil be required to undergo treatment against his will.

(3) Each school dentist or any dentist examining or treating pupils with the approval of the board of education shall record the results of examinations, treatment administered, and recommendations upon the health records of the pupils or upon dental health records provided for the purpose by the local board of education and recommended by the Commissioner of Education. In all other respects the rules relating to medical examination forms shall apply.

(4) The results of dental examinations or of treatment administered or recommended shall be reported to parents upon forms provided for the purpose by the board of education.

(5) Boards of education shall submit reports of the dental health service to the Commissioner of Education from time to time and in the form recommended by the Commissioner of Education.

e. *School Lunch* (*implementing R.S. 18A:18-5*)

(1) Cafeteria or lunchroom employees of boards of education whose duties include the preparation, cooking, or serving of food shall be required to be clean in person and clothing; familiar with the essentials of personal hygiene, sanitation, and disease prevention; and free of dental cavities, disease of the gums, skin disease, tuberculosis, syphilis in contagious form, or other communicable disease. A contractual requirement for such employees shall be a signed agreement to submit to a medical examination, to diagnostic tests for tuberculosis or syphilis, and to X-ray or fluoroscope examinations upon the request of the board of education.

(2) Boards of education shall comply with the regulations of the local, county, or State Department of Health governing the health or the employment of food handlers.

(3) Food handlers in the employ of boards of education shall be subject to all rules and procedures designed to prevent or control the transmission of communicable disease.

*(For districts which include this service in their health program).

(4) In a school district in which one or more cafeteria or lunchroom workers are employed, the board of education shall prescribe rules for the sanitary operation of kitchens and lunchrooms, which rles shall be posted in the kitchen and shall be explained to the kitchen and lunchroom employees by the medical inspector, nurse, or lunchroom manager at the beginning of each school year.

(5) The principal and the medical inspector or the nurse shall periodically inspect the school kitchen, lunchroom, and accessory rooms and equipment and shall report sanitary conditions found at each inspection together with recommendations, to the board of education.

(6) In districts in which cafeterias or lunchroom facilities are operated, board of education shall provide adequate facilities and equipment necessary for the sanitary and safe operation of such lunchrooms and cafeterias.

f. School Safety Services (pursuant to R.S. 18:2-4b)

(1) Every board of education in this State shall adopt rules to govern the supervision of pupil safety in its school district and such rules and regulations shall include as a minimum the rules and regulations of the State Board of Education which are expressed in the following sections.

Accident Prevention

(2) Principals shall introduce and administer precautionary measures and practices to prevent accidents, panic, and fire.

(3) The safety rules of the board of education and the preventive measures and practices applicable to local conditions shall be explained to the personnel by principals at the beginning of each school year and copies of the rules and procedures shall be posted in schools at points conveniently accesible to the personnel.

It shall be the duty of every local board of education maintaining courses in health, safety, physical education, practical arts education, and operating a cafeteria or lunchroom, to provide and maintain suitable and safe equipment.

Shop equipment shall not be used for any purpose other than shop instruction. The shop teacher shall be held responsible for the condition of shop tools and equipment, and he shall have full authority for its use for instructional purposes only.

Safety Patrols (implementing R.S. 18:14-92)

(4) Any organization of pupils whether designated as a patrol, council court, club, committee, or school police which has for its purpose the prevention of accidents to pupils in the school building, on the school grounds, on a sidewalk or path adjacent to a street, road or highway, or in a school bus or other vehicle approved for the transportation of pupils shall be regarded as an essential part of the school program and as a method of safety instruction and shall be employed and administered as such by the school personnel.

(5) The practice of using pupil safety patrols to direct pupil traffic

across streets, roads, or highways or to serve in any capacity shall be permitted only when approved by the board of education.

(6) No person, organization, or public agency shall organize, direct or instruct any form of pupil safety organization in a public school except as authorized by the board of education.

(7) A pupil desiring to serve on a school safety patrol or with any similar organization performing patrol duties shall file with the school principal a signed application form and a form of consent signed by one parent or legal guardian. The forms shall be provided by the board of education and they shall be worded in a manner to indicate that the applicant and his parent or guardian are aware of the possible hazards of patrol duty and that in case of injury to himself no liability shall be attached to the board of education or to any employee of the board of education.

(8) Boards of education shall cause all applicants for appointment to a safety patrol and their parents to be informed of the purposes and activities of the patrol and the possible hazards in line of duty.

(9) One or more members of the school staff shall be assigned to the safety patrol in the capacity of advisor or supervisor.

(10) Under no circumstances shall school patrols be vested with authority to direct vehicular traffic nor shall a patrol member stand in the street while vehicles are passing.

g. General Organization and Supervision of School Health Services (pursuant to R.S. 18A:4-15)

Cooperating Agencies

(1) Any program or plan sponsored or conducted by a person, an organization, or a public or private agency for the purpose of providing dental or nursing services, safety programs, athletic programs, lunchroom facilities, or any other services which aid in the preservation and promotion of the health of school pupils, through coordination with or as a part of the school organization regardless of the location of the facilities and equipment used, shall be under the jurisdiction of the board of education. The board shall approve all programs, have administrative direction of the pupils, and of the personnel working with the pupils, and shall approve and have control of records and reports.

Health Supervision

(2) Rules and practices adopted by boards of education to govern the supervision of pupil health, the hygienic management of classrooms by teachers, and the sanitary operation and maintenance of the school buildings, grounds, and equipment by custodians, matrons, and firemen shall be explained to the personnel annually by the principal, medical inspector, or nurse.

Care of the Injured Pupil

(3) Boards of education shall adopt rules and a program of procedures for the care of pupils injured at school and shall require that such rules and program be explained at the beginning of each school year to all employees and that copies be posted in each school at points conveniently accessible to the personnel.

Facilities, Equipment and Supplies

(4) Boards of education shall furnish each school building within their jurisdictions with an emergency kit or cabinet with first aid equipment and supplies prescribed by the medical inspector.

(5) Boards of education shall provide proper and adequate facilities for the medical inspector, dentist, and nurse, and the equipment and supplies necessary for the proper performance of their duties.

(6) Boards of education shall provide by regular appropriations suitable and adequate equipment for carrying out the program for physical education activities.

(7) Boards of education shall provide the necessary text and reference books, informational materials and teaching devices necessary for carrying out the instruction required by the statute in physical education, safety, alcohol, tobacco and narcotics.

h. School Hygiene and Health Facilities (pursuant to R.S. 18A:4-15)

Adequate school facilities shall include:

(1) Good drinking water within the school building or upon the school grounds. If within the school building, the water shall be available from faucet, drinking fountain, or closed container. No drinking water may be kept in open containers. Individual drinking cups shall be required, except where drinking fountains are in use.

Boards of education shall have drinking water from local sources tested at least once during each school year. The Commissioner of Education is authorized to designate the month during which a board shall submit samples of water to the State Board of Health, according to the schedule provided by the State Board of Health.

(2) Schools shall be furnished with adequate lavatory equipment. Such equipment shall be reasonable in amount and shall include lavatories or basins, an ample supply of water, liquid or powered soap, and individual towels. The equipment shall be kept in sanitary condition.

(3) All toilets shall be kept in sanitary condition and shall be supplied with toilet paper.

The Commissioner of Education shall require all boards of education to comply with the provisions of this rule.

NEW JERSEY STATE DEPARTMENT OF EDUCATION RULES AND RECOMMENDATIONS FOR TESTING FOR TUBERCULOSIS

The following are rules of the State Department of Education concerning testing for tuberculosis by school districts for implementation of N.J.S.A. 18A:40-16 which reads as follows:

> "The Board of Education of every school district shall periodically determine or cause to be determined the presence or absence of active or communicable tuberculosis in any or all pupils in public schools, and, with respect to frequency, procedure and selection of pupils, shall comply with rules and regulations of the State Board of Education."

RULES

1. The intradermal tuberculin tests shall be the sole basis of *initial* screening for tuberculosis in pupils.

2. An intradermal tuberculin test shall be given to the following pupils enrolled in elementary and secondary schools and the New Jersey School for the Deaf. The following are the minimum requirements:

a. All pupils in the first, fifth, ninth, and twelfth grades.

b. All post-graduate students.

c. All pupils in educable and trainable classes and any other special education classes whose grade levels are not defined at intervals of four years.

d. All new pupil admissions to a school district who come without a record of a previous intradermal tuberculin test administered within the past four years.

e. Any additional grades or classes which the school district might determine have a special risk of tuberculosis.

f. The only pupils exempt from these requirements shall be those pupils with documentation of a prior reaction to an intradermal tuberculin test of 10 millimeter or greater of induration or 4 plus Heaf test. Any other exemption from these requirements shall be for medical contraindications subject to review by the medical inspector.

3. a. A chest X-ray shall be administered to:

1. All pupils who are discovered to be tuberculin reactive at the time of initial testing.

2. All pupils exempted from the tuberculin test by section 2f above, at the time a tuberculin test would otherwise be done.

b. All pupils in need of a chest X-ray shall be referred to their family physician or other medical facility for the necessary medical examination, which must include a chest X-ray. A period of four weeks should be permitted for the family physician to report his findings to the school physician. If compliance with the time regulations is not fulfilled or the school physician fails to concur with the family physician's findings, then the tuberculin reactive pupil shall have a chest X-ray examination in a manner provided by the school district.

4. All employees (full time and part time) of a Board of Educationshall have an annual physical examination for tuberculosis in the manner outlined above for pupils. Included in this requirement are school cafeteria personnel, school bus drivers and any other personnel whose services may be contracted by the Board of Education and who have contact with pupils.

5. The reporting of the examination of testing for tuberculosis in each school district shall be as follows:

a. The name and address, grade and school of all *newly discovered* tuberculin reactive pupils and personnel are to be reported *immediately upon discovery* to the New Jersey State Department of Health on a special form provided so that the appropriate tuberculosis control measures can be implemented.

b. At the end of the annual tuberculosis testing program in each school district, the following reports shall be sent to the County Superintendent of Schools, the New Jersey State Department of Education, the New Jersey State Department of Health, and one to be retained by the local school district.

1. The number of tuberculin tests performed in each grade by school on pupils and on employees.
2. The name, address, grade, and school of all tuberculin reactors.
3. The results of all X-ray examinations performed on pupils and employees.

RECOMMENDATIONS

The following are recommendations for implementation of the foregoing rules:

1.) The generally available intradermal tuberculin tests, such as the Mantoux, Tine, Mono-Vac, Heaf and Stern Needle are acceptable for purposes of tuberculosis screening. *The patch test may not be used for screening purposes.*

2.) All students having tuberculin reactions less than 10 millimeters of induration by an intradermal test (Mantoux 5-9 mm, Tine 2-9 mm, Heaf grade 1) should be retested by a Mantoux test. Preferably, differential intradermal antigens should be used in accordance with the procedures of the New Jersey State Department of Health. Only pupils positive by these retesting procedures for infection by *Mycobacteria tuberculosis* should receive an X-ray, be exempted from further tuberculin testing, and considered for prophtlactic treatment. Local tuberculosis clinical facilities should be consulted for aid in these retesting procedures.

3.) The State Department of Education rule requiring tuberculosis screening of members of athletic teams prior to participation in sport programs has been eliminated. Members of athletic teams should be screened with their respective grades.

4.) School districts should consult with state and local health departments to determine whether or not tuberculosis tests are indicated beyond the minimal requirements.

5.) All pupils having a positive tuberculin test should be evaluated by a physician for consideration of the use of preventive therapy.

*These pages replace pages 85 and 86 (and amendments) as presently found in the January, 1964, edition of the *Rules and Regulations of the State Board of Education.*

REGULATIONS CONCERNING ISOLATION OF PERSONS ILL OR INFECTED WITH A COMMUNICABLE DISEASE AND RESTRICTION OF CONTACTS OF SUCH COMMUNICABLE DISEASE

The State Department of Health of the State of New Jersey, pursuant to authority vested in it by statute, hereby establishes the following Regulations concerning isolation of persons ill or infected with a communicable disease and restriction of contacts of such communicable disease. Any Regulations in these matters which may have been adopted heretofore by this Department are hereby rescinded.

These Regulations relate to and are to be used in conjunction with Chapter 2, Regulation 7 of the State Sanitary Code.

NEW JERSEY DEPARTMENT OF HEALTH

By:

s/ Roscoe P. Kandle
ROSCOE P. KANDLE, M.D.
State Commissioner of Health

Filed with Secretary of State: October 18, 1965
Effective Date: January 1, 1966; Change Date November 15, 1966

ADMINISTRATIVE REGULATIONS

November 15, 1966

DIPHTHERIA

REPORT REQUIRED

Minimum Period of Isolation of Patient

Until clinical recovery and until two successive cultures from nose and throat taken at least 24 hours apart are negative for virulent diphtheria organisms, such cultures being taken at least 7 days after the discontinuance of any antibiotic therapy.

All isolates of diphtheria should be submitted to the State Laboratory for virulence testing.

If a history of immunization exists, it is useful to perform a Shick test about one-half hour before administration of antitoxin, thus documenting the presence or absence of measurable circulating immunity to the toxin.

Minimum Period of Restriction of Contacts

ADULTS–

Household contacts who are food handlers or whose occupation involves close contact with children, e.g., nurses or teachers, shall be excluded from their occupation until at least two successive cultures from nose and throat taken at least 24 hours apart are negative for virulent diphtheria organisms, such cultures being taken at least 7 days after the discontinuance of antibiotic therapy. Such contacts and all other adult household contacts shall be kept under surveilance for at least 7 days from last exposure, then released from observation if nose and throat cultures taken as above are negative.

CHILDREN –

Household contacts shall be excluded from school or other public gatherings until at least two successive nose an throa cultures taken at least 24 hours apart are negative for virulent diphtheria organisms, such cultures being taken at least 7 days after the discontinuance of antibiotic therapy.

Household and classroom contacts shall be kept under surveillance for at least 7 days from last exposure.

All previously immunized adult and childhood household and classroom contacts should receive toxoid boosters. Non-immune household contacts with positive nose or throat cultures should receive 10,000 U of antitoxin i.m. phophylactically, and should at the same time be started on a course of active immunization with toxoid, injected at a different site. In those with positive cultures, the recommended therapy is 2,000,000 U Procaine Penicillin G i.m. daily for at least 7 days. In the absence of local facilities for performing cultures, swabs of nose and throat may be mailed in a sterile tube (*not* containing nutrient medium) to the State Laboratory.

HEPATITIS, INFECTIOUS (Type A)

REPORT REQUIRED

Minimum Period of Isolation of Patient

Until end of febrile period.

Minimum Period of Restriction of Contacts

Adults – No restrictions.
Children – No restrictions.

Due to the persistence of virus in feces for at least 1 to 2 weeks after the appearance of jaundice, appropriate care should be taken to prevent household spread by fecal-oral route.

It is recommended that all household contacts, particularly adults, receive within 14 days of the onset of illness in the index case a dose of gamma globulin equal to 0.01 cc./lb.

Household contacts are defined as individuals who have spent over 24 hours in the household or who have eaten food prepared by the index case. Even individuals who have a history of prior hepatitis should receive this prophylaxis (which modifies, though not necessarily prevents, disease if given early enough), as strain differences between various viruses may exist. Food handlers who are household contacts must be excluded from food handling for 21 days following onset of symptoms in the first household case. At the end of this period food handlers may return to work if: (a) they are in good health; (b) they have received gamma globulin; (c) they have been instructed by local health personnel in the scrupulous practice of personal hygiene.

Recent evidence indicates gamma globulin may decrease infectivity of persons carrying the infectius hepatitis virus. Food handlers who for any reason do not receive gamma globulin must be excluded from work for 45 days. Any food handler who is a household contact of a hepatitis case may, of course, continue to be employed in other capaiities where his duties do not include handling of food.

HEPATITIS, SERUM (Type B)

REPORT REQUIRED

Minimum Period of Isolation of Patient

As for Infectious Hepatitis.

Minimum Period of Restriction of Contacts

Adults – No restrictions.
Children – No restrictions.

Although classical serum hepatitis with Type B virus is not communicable except parenterally, there is no way of absolutely determining whether or not a given case of hepatitis is serum-transmitted Type A (Infectious-incubation period under 60 days, usually less than 42 days) or Type B (Serum-incubation period of 60 days or more), even if there is a history of prior transfusion, etc. Therefore all cases of hepatitis should be managed as if they were Infectious-Type A.

It is not generally recommended that hospital personnel caring for a case of hepatitis receive gamma globulin prophylactically. It is not generally recommended that any person receiving blood products at any age routinely receive gamma globulin prophylaxis against serum-transmitted hepatitis, theefficacy of which and dosage for which remains under investigation.

MEASLES (Rubeola)

REPORT REQUIRED

Minimum Period of Isolation of Patient

None.

Minimum Period of Restriction of Contacts

No restrictions.

Recommendations and Comments

This patient should be excluded from school until seven days from appearance of rash.

It is recommended that parent of school children be notified upon the appearance of the first case of measles in the school, with the recommendation that non-immunes immediately consult their physicians regarding the receipt of measles vaccine of the live virus type in one of the proven schedules. Such prompt action may be expected to abort a major measles epidemic. In addition to the administration of live vaccine, classroom contacts, siblings, and playmates, who are non-immune should also receive gamma globulin. Such globulin is available for indigent patients from biological distributing stations of the State Department of Health, being supplied by the American Red Cross. The preventive dose of 0.10 cc./lb. is recommended for the chronically ill children, children with disturbed immunologic mechanisms (in whom live vaccine is contraindicated, and who should electively receive killed vaccine), and in children below the age of three years. All others should receive the modifying dose of 0.02 cc./lb. if given within the first 6 days after the onset of rash in the first household case or 0.04 cc./lb. if given thereafter.

All susceptible children one year of age or older should receive measles vaccine. Attenuated live-virus vaccines provide lasting active immunity. Killed vaccine is available for children with special immunologic problems. In view of the significant incidence of pneumonia, otitis, encephalitis, and death occurring as sequellae to measles, eradication of this disease by use of presently available vaccines is urgent.

MENINGITIS, MENINGOCOCCAL

REPORT REQUIRED

Minimum Period of Isolation of Patient

Until end of febrile period, or until 24 hours after the administration of sulfadiazine or penicillin has begun. Other forms of meningitis require no restrictions as covered elsewhere in this code.

Minimum Period of Restriction of Contacts

No restrictions.

Family members and other close personal contacts of the index case should receive prophylaxis with sulfadiazine (0.5 gm. orally twice daily for 2 days in children, or 1.0 gm. orally twice daily for 2 daysi adults.

Mass sulfadiazine prophylactic treatment of asymptomatic institutional contacts will only contribute to the increasing problem of sulfa-resistant meningococci. While penicillin has become the treatment of choice for individual cases, it is ineffective in long-term eradication of the carrier state when used in programs of mass prophylaxis. In addition, penicillin resistant organisms exist in the laboratory and could at any time become a serious clinical problem.

POLIOMYELITIS

REPORT REQUIRED

Minimum Period of Isolation of Patient

No restrictions, except for hospitalized patients, when patient should be treated as any other enteric infection.

Minimum Period of Restrictions of Contacts

Adults – No restrictions.
Children – No restrictions.

Adequate prevention of further cases of poliomyelitis depends today purely on the induction and maintenance of immunity through the use of killed or live attenuated vaccines, the latter being preferred, except in unusual instances. It is imperative that early stool specimens and acute (within 3 days of the onset of paralysis) and convalescent blood specimens be obtained in cases suspected of being due to poliomyelitis virus so that isolation and identification of the virus may be made and knowledge gained as to its type for use in preventing an outbreak, if such seems imminent.

Hospitals with poliomyelitis patients on their wards may, if the type is known find it more useful to immunize exposed staff and even fellow patients with oral vaccine than to depend upon relatively ineffective precaution techniques.

Administration of oral vaccine should generally be reserved for the non-poliomyelitis season, to obviate erroneous implication of the vaccine in cases caused by naturally circulated wild virus. The exception to this dictum is in the presence of an outbreak of poliomyelitis, at which time mass administration of type-specific vaccine is in order to abort the epidemic. If the virus type is unknown, triple vaccine may be used, although less effective. Killed (Salk) vaccine is of little use in an epidemic among unvaccinated individuals, though it may be of use in well-vaccinated persons.

SALMONELLOSIS (Except Typhoid Fever)

REPORT REQUIRED

Minimum Period of Isolation of Patient

Until clinical recovery. Food handlers and adults whose occupations involve intimate care of children shall be excluded from their occupations until three successive, authentic, stool cultures taken at least 7 days after specific antimicrobial therapy has been discontinued, and at least 24 hours apart, are negative. Food handlers, etc., whose infection was diagnosed as having invaded the blood stream must also submit evidence that three successive, authentic urine specimens taken at least 7 days after specific antimicrobial therapy has been discontinued, and at least 24 hours apart, are negative before they may return to their occupations.

Minimum Period of Restriction of Contacts

Adults – No restrictions, except for food handlers and adults whose occupation involves intimate care of children. Such individuals shall be governed as are cases. They may not begin to submit the requisite stool specimens until termination of their contact with a stool-positive case.

Children – No restrictions.

Salmonellosis (including Salmonella Food Poisoning and

Paratyphoid) appears to be increasing in terms of the number of reported cases, if not also in true incidnce. Search for source of illness among contaminated foods asymptomatic human carriers, and symptomtic or asymptomatic household pets, may be useful if investigation is undertaken early. Suspected foods should be placed in sterile containers (or left in their own containers) and refrigerated until samples may be submitted for laboratory examination. Investigation is most useful where multiple cases occur and when started early.

It should be noted that antibiotic therapy of the gastrointestinal illness and the carrier stage is often unrewarding, despite apparent in vitro antibiotic sensitivity, and repeated, prolonged courses of antibiotic therapy do not usually resolve that which does not respond in previous courses. If local facilities are not available, stools may be mailed to the State Laboratory in kits provided by the Division of Laboratories.

Routine stool cultures at the time of employment of food handlers, and at the time of admission of inmates to institutions, are of little use in the prevention of Salmonellosis and are not recommended.

SMALLPOX (Variola)

REPORT REQUIRED

Minimum Period of Isolation of Patient

Two weeks from onset of disease and until all crusts or scabs have fallen off. It is recommended that patients who are only mildly ill *not* be hospitalized but be cared for in their homes if possible.

Minimum Period of Restriction of Contacts

Adults — For 16 days from last exposure unless immunized by previous disease or by previous successful vaccination, in which case the contact may be released from quarantine but maintained under surveillance following successful revaccination. (See below).

Children — As for adults.

Special instructions on the nursing and precaution technique o be applied to cases of smallpox are available from the Division of Preventable Diseases, State Department of Health, Trenton, 609-292-5590. Notify at once by phone.

It is recommended that, because of increasing foreign travel by air and increasing likelihood of the importation of cases of smallpox into this country, individuals with a high risk of exposure maintain a reguler program of revaccination every 3 years. These individuals include physicians and all hospital personnel, airport and overseas airline employees, longshoremen, taxi drivers, policemen, anbulance drivers.

If a patient with suspected smallpox is hospitalized, all hospital personnel *and patients* should be immediately revaccinated irrespective of the time of their most recent vaccination. No patint should be admittee to the hospital who presents serious contraindication to vaccination. If hospitalization of such an individual cannot be deferred or done elsewhere, immunization may be performed followed in 12 hours by the administration of 0.3 ml./kg. of vaccinia immune globulin available from Red Cross Regional Blood Center only upon release by a designated consultant, who for this New Jersey area is:

Horace Hodes, M.D.
Pediatrician-in-Chief
Mt. Sinai Hospital
New York, New York 10029
212 TR 6-1158 or
212 TR 6-1000 Ext. 732
Home: Long Island, New York
516 MA 7-3691

Alternate:
Eugene Ainbender, M.D.
Department of Pediatrics
Mt. Sinai Hospital
New York, New York 10029
Phone: Same as for Dr. Hodes
Home: Ossining, New York
914 RO 2-1148

Instructions for follow-up of Smallpox Surveillance Orders of the Foreign Quarantine Division of the U.S. Public Health Service or the National Health Service of the Dominion of Canada:

INADEQUATE VACCINATION

In the case of a person entering this country who is designated a surveillance *subject* (for a multiplicity of reasons) and who has *not* been exposed to a known or suspect active smallpox case within the fourteen (14) day period prior to his arrival:

1. The health officer is to instruct the person to report to him any illness no matter how trivial.
2. The health officer is to determine from the person who may be ill the name of his physician.
3. The health officer is to instruct the person to visit the physician.
4. The health officer is to obtain from the physician the diagnosis of the current illness.

Where any possibility of the diagnosis being smallpox exists in the physician's mind, the State Health Department must be consulted immediately at 609 292-5590. After hours, a department representative may be contacted by calling 609 396-6067.

5. A person subject to surveillance in this category need not be restricted or quarantined. His family contacts need not be re-immunized.

6. The health officer does not need to maintain daily contact with the person if he is believed to be a responsible individual.

7. Quarantine Division forms are to be completed and returned at the end of the period of surveillance.

8. The Division of Preventable Diseases is to be notified by telephone that the person under surveillance is well.

KNOWN OR SUSPECT EXPOSURE TO SMALLPOX

In the case of a person entering this country who has been reported as having had contact with a known or suspect case of smallpox within the fourteen day period prior to his entry, information will be telephoned to the health officer by this Department.

1. The health officer shall assure that the person under surveillance is immediately vaccinated, with the following exceptions:

    a. The person presents evidence of a fresh vaccination crust.

    b. The surveillance request states that the erson was vaccinated on arrival in the United States.

    c. If a family member has eczema, then either that individual or the surveillance subject must be excluded from the remainder of the household, but the surveillance subject *must* be vaccinated.

2. The health officer shall assure that the immediate family and intimate contacts of a personunder surveillance are immediately vaccinated. The only exception to this rule is the presence of eczma in the family member or contact: In this case, vaccinia immune globulin is to be administered to the family member or contact.

3. The health officer is to obtain the name of the subject's physician, contact the physician and inform him concerning the necessary surveillance procedures.

4. The health officer is to instruct the person under surveillance and the physician to report immediately to him any illness, no matter how trivial.

5. The health officer is to see or call the patient daily until the end of the surveillance period. The subject should be instructed to check his temperature each evening and report any elevation to the health officer.

6. The person under surveillance should restrict his activity. If his work brings him into contact with large numbers of people he should

stay home from work, and he should avoid attendance at public functions, parties and family gatherings, movies, etc.

7. Restriction is not necessary for his contacts or family.

8. The health officer is to assume that any surveillance order he received is of the type requiring the measures outlined in "Inadequate Vaccination" above, unless he is specifically notified by the State Health Department to the contrary.

9. Questions regarding these measures should be directed to the Division of Preventable Diseases, 609 292-5590.

TYPHOID FEVER

REPORT REQUIRED

Minimum Period of Isolation of Patient

Until clinical recovery. Food handlers and adults whose occupations involve intimate care of children shall be excluded from their occupations until three successive, authentic stool *and* urine cultures taken at least 7 days after specific antimicrobial therapy has been discontinued, and at least one week apart, are negative. All other patients must be kept under surveillance until the above cultures have ben submitted, but may return to their occupations.

Minimum Period of Restriction of Contacts

Adults – No restrictions, except for food handlers and adults whose occupation involves intimate care of children. Such individuals shall be governed as are cases. They may not begin to submit the requisite stool specimens until termination of their contact with a stool-positive case.

Children – No restrictions.

Commencing at least 90 days after the cessation of antimicrobial therapy, four additional, authentic samples of both stool and urine must be submitted at least 3 months apart. If any of the cultures in this period are found positive, the patient shall be declared a carrier.

Carriers may not handle food or food poducts to be consumed by persons other than the members of their immediate household, may not reside in the same household as a dairy worker or other food handlers, may not send soiled undergarments to a public laundry unless they have been previously boiled or otherwise disinfected, and must notify their local board of health or the State Department of Health of change of permanent residence.

It is recommended that household contacts of a carrier be immunized with Typhoid Vaccine (0.5 cc s.c. at each of 3 injections at least one week apart, followed by boosters at yearly intervals) while high risk of exposure remains.

A person who has been determined to be a chronic fecal or urinary carrier and who has undergone such therapeutic procedures as are, in the opinion of the State Department of Health, likely to result in the elimination of his carrier status, may be relased if eight successive, authentic stool and/or urine specimens taken at intervals of not less than one month are determined to be negative in a laboratory approved by the State Department of Health. An authentic specimen will usually be a direct specimen obtained under supervision of a health officer, or his agent, or following the patient's ingestion of a vegetable dye marker in the presence of a health officer, his agent, or a member of the staff of the State Department of Health, which is then noted to be present in the specimen submitted. Such dye markers may be obtained from the Division of Preventable Diseases, State Department of Health.

Refusal of a case or suspected case or carrier of typhoid fever to submit specimens requires the issuance of an order to submit to such examination by the local board of health under *RS26:4-50.* Failure to respect this order leads to an appeal to the courts under *RS26:4-51 to 57* for an order which may be enforced under the State's police powers.

Reliance should not be placed upon the Widal Agglutination test in the diagnosis of Typhoid Fever, as the results of these tests are very often misleading. A four-fold or greater rise in titer in two serum shecimens taken several days apart, but run simultaneously in the same laboratory, may be considered highly suggestive of the diagnosis, but cultures of blood, urine and stool will give a more definitive diagnosis and often give it earlier.

Routine stool cultures at time of employment of food handlers and at time of admission of inmates to institutions are of little use in the prevention of Typhoid Fever and are not recommended.

MUMPS

REPORT NOT REQUIRED

Minimum Period of Isolation of Patient

None.

Minimum Period of Restriction of Contacts

No restrictions.

Recommendations and Comments

The patient should be excluded from school for the period of acute illness, but no longer than six days

Hyperimmune anti-mumps globulin is commercially available only. 5 to 7.5 cc. may be given to adults with a negative skin test up to 24 hours after onset of parotitis in the recipient to prevent complications of orchitis, although its efficacy is not proven. Presumably the earlier it is given after exposure, the more effective innume globulin might be. A commercial skin test is 75 per cent reliable in differentiating those who have had inapparent infection in the past (40 per cent), on the basis of erythema at the site of the intradermal injection within 18-24 hours.

As with many of the viral diseases of childhood, isolation of the patient is not a major importance in the prevention of outbreaks, as the virus is spread for at least one week prior to the onset of diagnostic symptoms. Children should, except in unusual circumstances, be permitted to obtain active immunity to the infection, and should not receive prophylactic mumps-immune globulin.

PERTUSSIS (Whooping Cough)

REPORT NOT REQUIRED

Minimum Period of Isolation of Patient

None.

Minimum Period of Restriction of Contacts

No restrictions.

Recommendations and Comments

The patient should be excluded from school until clinical recovery and for three weeks after the onset of typical paroxysms. Contact with unvaccinated infants should be avoided.

Unless culturing on Bordet-Gengou medium is done, many atypical cases will be missed, while many cases will be erroneously diagnosed as whooping cough in the non-specific catarrhal stage. Antibiotic therapy cannot be depended upon to reduce the communicability of illness. Non-immune, childhood contacts, especially those under age 3, should receive 2.5 cc. of hyperimmune antipertussis globulin as soon after exposure as possible, this material being commercially available, although not supplied by the State to indigent patients.

Contacts should be seen daily at school by a nir or physician for a period of 14 days from last exposure to a known case, but may attend school if no symptoms of respiratory infection are detected. Previously immunized childhood contacts should receive a booster dose of 4 National Institute of Health units of unabsorbed pertussis vaccine.

RUBELLA (German Measles, 3-Day Measles)

REPORT NOT REQUIRED

Minimum Period of Isolation of Patient

None.

Minimum Period of Restriction of Contacts

No restrictions.

Recommendations and Comments

Children should be excluded from school until three days from appearance of rash.

Exposure of pregnant females (e.g., schoolteachers) is especially to be avoided. Exposed non-immune pregnant females in the first trimester should receive 20 cc. of gamma globulin i.m. within one week of exposure, the earlier the better. The medication will be supplied to indigent patients upon request by their physician to the Division of Preventable Diseases, from whence it is mailed by Special Delivery the same day the request is received. The therapy is of dubious effectiveness even if given at the optimal time, in reducing the incidence of congenital malformations or fetal loss.

It is highly recommended that non-immune, non-pregnant females be exposed to cases of this disease as prophylaxis against subsequent infection while pregnant, the illness being uniformly mil and the immunity permanent.

STREPTOCOCCAL INFECTIONS
(Includes Scarlet Fever, Sore Throat, Erysipelas)

REPORT NOT REQUIRED

Minimum Period of Isolation of Patient

None.

Minimum Period of Restriction of Contacts

No restrictions.

Recommendations and Comments

Children should be excluded from school until clinical recovery and the disappearance of purulent discharges, or until 24 hours afte the commencement of specific antimicrobial therapy, provided such therapy is continued for at least 10 days.

It is strongly recommended that all children who are close personal contacs, especially household contacts, of cases of streptococcal disease receive throat culture with treatment of positives with specific chemoprophylaxis which is continued for 10 days. The recommended therapy is penicillin (or erythromycin if penicillin allergy exists), 250,000 units p.o. four times daily or 1 million units aqueous procaine penicillin i.m. daily or a single dose of 1.2 million units of benzathine penicillin i.m. In the absence of local facilities for culturing, dry swabs may be mailed in sterile empty tubes to the State Laboratory.

CHICKENPOX (Varicella)

REPORT NOT REQUIRED

Minimum Period of Isolation of Patient

None.

Minimum Period of Restriction of Contacts

No restrictions.

Recommendations and Comments

Patients should be excluded from school until six days after onset of rash. All crusts and scabs need not have fallen off.

Gamma globulin is not supplied to indigents by the State for this illness, nor is this therapy recommended for routine use. It may be useful in modifying (but not preventing) illness if given early after exposure at 0.2 cc./kg., and such treatment may be considered in individuals with no past history of varicella who are taking high doses of steroids or are suffering from diseases with altered immunologic responsiveness (e.g., leukemia, Hodgkin's disease, myeloma).

VENERAL DISEASE TREATMENT
QUICK REFERENCE SUMMARY

SYPHILIS (Primary, secondary and latent with nonreactive spinal fluid)	Benzathine Penicillin G	2,400,000 units intramuscularly at a single session
SYPHILIS (Early latent and late latent if no examination of spinal fluid is mad)	Benzathine Penicillin G	6,000,000 units total, divided evenly in two sessions seven days apart.
LATE SYPHILIS (Cardiovascular, late benign, and neurosyphilis)	Benzathine Penicillin G	6,000,000 to 9,000,000 units given 3,000,000 units per session at seven-day intervals
CONGENITAL SYPHILIS (under 2 years' duration)	Aqueous Procaine Penicillin G	50,000 units per lb. body weight 10 equally divided daily injections
CONGENITAL SYPHILIS (Over 2 years' duration nonreactive spinal fluid) (if spinal fluid reactive, treat as neurosyphilis)	Benzathine Penicillin G	2,400,000 units intramuscularly at a single session. Should be adjusted for age and body weight.
GONORRHEA	Aqueous Procaine Penicillin G	Men: 2,400,000 units in one intramuscular injection. Women: 4,800,000 units intramuscularly in two injection sites at one visit
CHANCROID	Sulfadiazine	One gram orally four times a day for seven days, to a total of 28 grams
GRANULOMA INGUINALE	Tetracycline or Erythromycin	500 mg. orally 4 times a day for 15 days 500 mg. orally 4 times a day for 15 days
LYMPHOGRANULOMA VENEREUM	Sulfadiazine or Tetracycline	One gram orally 4 times a day for 15 days 500 mg. orally 4 times a day for 15 days

VENEREAL DISEASE TREATMENT QUICK REFERENCE SUMMARY

VENEREAL DISEASES

Syphilis
Gonorrhea
Chancroid
Granuloma Inguinale
Lymphogranuloma Venereum
Ophthalmia Neonatorum

REPORT REQUIRED

Minimum Period of Isolation

Isolation is not required while patient is under treatment.

In *Ophthalmia Neonatorium* isolation is required until cure is achieved.

Minimum Period of Restriction of Contacts

None.

Sexual contacts should be considered infected and infectious until examination (physical and laboratory) rules out infection, or until epidemiologic treatment is given.

Because of persistent increases in infectious syphilis, routine reporting, diagnosis, treatment, and epidemiology are no longer sufficient. Emergency action is needed in every case.

All physicians, hospitals and clinics are urged to consider every primary, secondary or recently infectious case of syphilis as a medical and public health emergency, and to report every early syphilis case by telephone to the State Department of Health in order that the patient may be interviewed for contacts immediitely.

Physicians are invited to telephone requests for assistance in darkfield examination of suspicious lesions *prior to treatment.* *EPIDEMIOLOGICAL, CONSULTATIVE,* and *DARKFIELD* services are available by calling Area Code 609-392-2020 immediately. This service is rendered on a 24 hour, 7 day-a-week basis.

Departmental representatives, Field Epidemiologists, trained to give this assistance are located strategically throughout the State.

Within an hour they will make detailed arrangements for rendering the darkfield service, and performing the necessary cntact interview of the patient, or both. In most instances the epidemiologist can be in the doctor's office in less than two hours after the initial call.